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OPTIONS IN ACCESS TO HEALTH CARE

HEARING

BEFORE

THE PEPPER COMMISSION

U.S. BIPARTISAN COMMISSION
ON
COMPREHENSIVE HEALTH CARE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

WASHINGTON, DC

OCTOBER 24, 1989

PART 9

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OPTIONS IN ACCESS TO HEALTH CARE

TUESDAY, OCTOBER 24, 1989

The Pepper Commission
U.S. Bipartisan Commission on
Comprehensive Health Care
Washington, DC.

The Commission met, pursuant to notice, at 9:18 a.m., in room 106 of the Dirksen Senate Office Building, Hon. John D. Rockefeller IV (Chairman of the Commission), presiding.

Present: Senator John D. Rockefeller IV, Senator Max Baucus, Senator Dave Durenberger, Senator John Heinz, Representative Bill Gradison, Representative Fortney Pete Stark, Representative Louis Stokes, Commissioner James Balog, and Commissioner James Davis.

Also Present: Edward F. Howard, general counsel; Steven C. Edelstein, Robert B. Friedland, Monica E. McFadden, Philip Shandler, Judith G. Waxman, Joy Johnson Wilson, professional staff; S. Mitchell Weitzman, staff assistant; and Jackie Shields, intern.

OPENING STATEMENT OF CHAIRMAN JOHN D. ROCKEFELLER IV

Chairman Rockefeller. If the hearing could come to order, please. The Chairman apologizes for being late.

Today we, the Pepper Commission, complete our series of public hearings in Washington to help us in our work. Because our mission is a design of a plan of action, we are deliberately asking our witnesses to help us with their expert advice and with their insights in identifying and considering real options and real solutions to the problems that we all, obviously, desperately want to solve. I say every chance I can, please help us find the road that Congress, the administration, and others can and should take together to bring about access for all Americans to affordable, adequate health care.

The focus of this morning's hearing is, once again, on the uninsured. We know that there are between 31 and 37 million Americans who have no health insurance of any sort, and we know that there are probably another 20 million who are underinsured, with coverage that exposes them to unmanageable, sometimes devastating, financial cost for needed care. Imagine, over one-quarter of our Nation's citizens under age 65 do not have adequate health insurance. As many as 15 million Americans annually are denied care or do not even seek it because they cannot afford it.

As staggering as these figures are, they could never truly convey the extent of this problem, the anxiety, that is, and the emotional distress that it inflicts on families, and the dire consequences that it has for so many of our citizens. We have heard of these consequences first hand, not only in our hearings, but also in our travels across this country.

From a Tennessee couple who ran into frightening obstacles when trying to get emergency care for their son because they had no insurance, even though they were both employed and promised to pay for the care.

From the woman in Cleveland who owns her own business and makes over $72,000. She certainly could afford to buy insurance, but cannot find a company willing to sell it to her because of a preexisting condition.

From the woman from Minnesota whose child was born severely brain damaged and then ultimately died because she did not have access to adequate prenatal and obstetrical care. Her son's care eventually cost some aspect of our country's health system over $180,000, the same system that was trying to save the $2,000, at the most, that it would have cost to provide her with topnotch maternity care.

These people are all from working families, which should not surprise us, because 80 percent of the uninsured are workers or members of working families. Health insurance is a matter of increasing concern in our Nation's workplaces. We have heard frequently from representatives of major corporations that the rising cost of health care, health insurance, threatens their competitiveness, despite their size. It is beyond their ability, they tell us, to control costs.

Representatives of our Nation's labor unions report that health benefits have become one of the most contentious issues in contract negotiations. The corporations try to rein in costs. That's something we're familiar with in West Virginia.

Some have said that no action will be possible on the uninsured unless there's a crisis. I say back, listen to the testimony that we have heard, look at the figures that we have read, study the problem that we have tried to look into, and a crisis or something very close to it cries out. And while we have just begun searching for a consensus on a strategy to end this crisis, I can report to you that we, the members of the Pepper Commission, share a common belief that fundamental changes to enable have to be made in our health care system, in order that millions of Americans without adequate health insurance can get decent and affordable coverage.

So, we need to act. We're determined to act. We are determined to act thoughtfully, but we are not afraid to act boldly. And today we seek to benefit from your knowledge and from your experience, to guide us in our effort. Together the business community, the consumers, the providers, and Government, ought to be able to craft a uniquely American solution to this unfortunately uniquely American problem, which is lack of health care coverage in the most affluent society in the world.

[The prepared statements of Chairman Rockefeller and Senator Pryor follow:]

OPENING STATEMENT
by
SENATOR JOHN D. ROCKEFELLER IV, CHAIRMAN

at a hearing of the

PEPPER COMMISSION
(U.S. Bipartisan Commission on Comprehensive Health Care)

Tuesday, October 24, 1989
Washington, DC

Today we, the Pepper Commission, complete our series of public hearings in Washington to help us in our work. Because our mission is to design a plan of action, we are deliberately asking our witnesses to assist us with their expert advice and insights, in identifying and considering real options and real solutions to the problems we all want so desperately to solve. As I say every chance I can, please help us find the road that Congress, the Administration, and others can and should take together to bring about access for all Americans to affordable, adequate health care.

The focus of this morning's hearing is on the problem of the uninsured. We know there are between 31 and 37 million Americans without any health insurance protection, and another 20 million underinsured, with coverage which exposes them to unmanageable, sometimes devastating, financial costs for needed care. Imagine, over one quarter of our nation's citizens under age 65 do not have adequate health insurance. As many as 15 million Americans annually are denied care -- or do not even seek it-- because they cannot afford it.

As staggering as these figures are, they could never truly convey the extent of this problem -- the anxiety and the emotional distress it inflicts on families, and the dire consequences it has for so many of our citizens.

We heard of these consequences first-hand, at our hearings in Washington and across the country:

-- From a Tennessee couple who ran into frightening obstacles when trying to get emergency care for their son because they had no insurance, even though they were both employed and promised to pay for the care.

-- From the woman from Cleveland who owns her own business and makes over $72,000 a year. She could certainly afford to buy insurance, but cannot find a company willing to sell it to her because of a preexisting condition.

-- From the woman from Minnesota, whose child was born severely brain damaged and ultimately died because she did not have access to adequate prenatal and obstetrical care. Her son's care eventually cost some aspect of our country's health care system over $180,000 -- the same system that was trying to save the $2,000 it would have cost to provide her with topnotch maternity care.

These people are all from working families, which shouldn't surprise us: 80 percent of the uninsured are workers or members of working families.

Health insurance is a matter of increasing concern in our nation's workplaces. We have heard from representatives of major corporations that the rising cost of health insurance threatens their competitiveness. Despite their size, it is beyond their ability to control costs. Representatives of our nation's labor unions report that health benefits have become one of the most contentious issues in contract negotiations as corporations try to rein in costs.

Some have said that no action will be possible on the uninsured unless there is a crisis. I say back: listen to the testimony we have heard, look at the figures we have read, study the problem they way we have tried to do, and a crisis -- or something very close to it -- cries out. And while we have just begun searching for a consensus on strategy to end this crisis, I can report to you that we, the members of the Pepper Commission, share a common belief that fundamental changes must be made in our health care system to enable the millions of Americans without adequate health insurance to get decent and affordable coverage.

We need to act now. We need to act thoughtfully, but boldly. And today, we seek the benefit of your knowledge and experience to guide us in our effort. Together, the business community, consumers, providers and government can craft a uniquely American solution to this uniquely American problem: lack of health care coverage in the most affluent society in the world.

DAVID PRYOR, ARKANSAS, CHAIRMAN

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United States Senate
SPECIAL COMMITTEE ON AGING
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OPENING STATEMENT

SENATOR DAVID PRYOR

Chairman, U.S. Senate Special Committee on Aging

before a

Pepper Commission Hearing

on

OPTIONS IN ACCESS TO HEALTH CARE

9:00 a.m.
October 24, 1989

Senate Dirksen 106
Washington, D.C.

Good morning. I am pleased to join Chairman Rockefeller in convening this the third Pepper Commission hearing held in our nation's capitol.

Today we will be exploring and evaluating various options to assure that all Americans have access to affordable health insurance. We have an extraordinary collection of witnesses before us, so my opening remarks will be brief.

As Chairman of the Senate Special Committee on Aging, however, I think it is important to note the commitment the aging community has to this issue. The Chairman of the House Aging Committee, Congressman Edward Roybal, and representatives from such groups as the AARP and the National Council of Senior Citizens are here today to offer their support and suggestions for assisting the millions of uninsured of our nation -- a group which is almost entiremly made up of people under the age of 65.

Far from being the so called "greedy geezers" that so many are labeling the elderly these days, older Americans and their representatives are obviously committed to developing a health care policy that addresses the many needs of the under 65 population as well as their own needs. We take this approach because we have long recognized that good health care policy is not a generation dividing issue, but a generation uniting issue.

Uniting all age groups of people who are in need of health care into multi-generational coalitions strengthens rather than diminishes attempts to reform and make more accessible our health care system. We must all try to remember this as we continue to witness those who try to pit the "needs" of the young against the "needs" of the old -- as though they are mutually exclusive.

There is no doubt that assuring access to needed health care for all generations is one of the greatest and potentially most expensive challenges confronting this nation. So far we have come painfully short of meeting this challenge.

Having said this, I feel confident we can and we will meet this challenge with the obvious commitment we have seen and we will continue to see today from Chairman Rockefeller and the members of the Pepper Commission, consumers and their representatives, the business community, health care providers, insurers, and Federal, State and local governments. It is my hope and expectation that the impresssive witnesses we have assembled before us will help us take a step forward and toward achieving a goal we all share -- access to protection against health care costs for vulnerable Americans of all ages.

Chairman **Rockefeller**. Congressman Roybal, we are honored, sir, to have you with us. We're grateful for your patience.

And Indeed, Congressman Walgren, we're very delighted to have you. We've known each other for many years. We come from adjacent territory.

Barbara Matula, you're also on the first panel. You've skipped up one, but that's fine. You have to leave early, I take it.

Ms. **Matula**. No; I'm sorry. They had me down on the first panel. They've changed that?

Chairman **Rockefeller**. No; that's quite all right. We'll do the two Congressmen first, if we might, and then we will do you. But you be comfortable.

Congressman Roybal, we welcome you, sir.

STATEMENT OF REPRESENTATIVE EDWARD R. ROYBAL

Representative **Roybal**. Thank you, Mr. Chairman. First of all, I'd like to thank the committee for the opportunity of being here this morning and to compliment the Chairman for an opening statement that clearly states the problem.

I am here today, Mr. Chairman, to join forces with the Commission and to help move forward an agenda of providing affordable and quality protection to the many millions of uninsured and underinsured Americans. One of the many vehicles that can be used to accomplish this is my national health plan proposal and that is the "USHealth Act" (H.R. 2980).

As the member who worked with Claude Pepper on the enabling legislation that established this historic Commission, I want you to know that I firmly believe that you have great potential to meet your mandate of section 402. I think we are all aware of the fact that that section is very clear and very precise. It says that the Commission shall make specific recommendations to the Congress respecting Federal programs, policies, and finally financing needed to assure, and it goes on and enumerates, as you know, what it is supposed to assure. (A) Comprehensive long-term care services for the elderly and disabled, (B) comprehensive health care services for the elderly and disabled, and then the third is comprehensive health care services for all individuals in the United States.

It is clear and it is precise. As mandated in your enabling legislation, yours is the Bipartisan Commission on Comprehensive Health Care. In my view, the Commission cannot discharge its responsibility with anything less than a comprehensive plan, not just for the poor or the rich or the elderly. Your recommendations must provide comprehensive protection for all Americans, not just for physician and hospital care. Your recommendation must provide comprehensive health and long-term care for all, not just in certain States. Your recommendation must provide comprehensive nationwide protection for all Americans.

Though some argue for piecemeal or partial solution to these problems, Congress should support a comprehensive solution. The Medicare Catastrophic Coverage Act is one example of a piecemeal approach. The failure of either business or Government by itself to contain certain care costs is another argument against piecemeal approaches.

It is my opinion, Mr. Chairman, that your recommendation should expand Medicare to provide basic health and long-term care benefits for all Americans, regardless of age or income. The bill should cover primary, acute, and long-term care, with special safeguards for catastrophic illness. As a tradeoff to secure this protection, it should set a national health and long-term care expenditure cap. Even with tight budgets, Congress needs to take on this most difficult issue.

The right of every American to necessary health care can no longer be denied. We can no longer ignore that there are 31 to 37 million Americans lacking insurance for basic and catastrophic health care. Over 200 million Americans lack long-term care protection and risk financial disaster when hit by a catastrophic, chronic illness.

A national health plan, Mr. Chairman, should build on the base of the Medicare Program and insure that all Americans are entitled to basic and catastrophic health insurance, as well as comprehensive, flexible, managed, and cost-capped long-term care coverage. You must prepare a comprehensive national health plan, one that dismantles existing financial barriers to health care, slows the Nation's escalating health care costs, and improves health care quality. Also the plan should take the unprecedented step of imposing a health and long-term care cost cap at 12 percent of the gross national product.

Without such an approach the Nation's health costs are projected to reach as high as 15 percent of the gross national product by the year 2000. Yet, despite this national investment, we still would not resolve the crises facing people with catastrophic illness and people without adequate health insurance protection. Setting a national health and long-term care expenditure cap is a fair tradeoff to secure comprehensive protection for all Americans.

Your recommendations should include a carefully articulated system for providing long-term care protection. Long-term care expenditure should be capped at 1.1 percent of gross national product and managed through a care management system, which insures that beneficiaries receive the care they need and that taxpayers will not face increases in costs beyond increases in their ability to pay.

In the interest of making people aware of the cost of health care, cost sharing should be required on 20 percent of medical and skilled nursing home care, and 25 percent of nonskilled long-term care. This cost sharing should be capped by catastrophic limits of $600 per person for medical and skilled nursing care, and $1,000 per person per year for nonskilled long-term care.

Health care providers should be paid prospectively based on DRG's [diagnostic related groups], for hospital care and a relative value scale for physician care. These fees should be developed in consultation with the representatives of health care providers and indexed to our Nation's ability to pay.

This Commission must recommend legislation that brings about critically needed improvements, without disrupting the essential professional and personal relationship between individual patients and their health care providers. Patient and health care provider freedom of choice should be preserved. Patients should be free to continue the relationship with their existing physician or hospital, and free to choose among fee-for-service or capitation providers. Health care providers of all types should be included, including public providers and private profit and not-for-profit providers.

Further, this Commission, in its recommendations, should create a special partnership with the Nation's insurance industry, which protects the financial viability of those companies, while insuring comprehensive coverage for every American. It should give insurance companies a valuable role, through contracts for a much larger volume of bill processing and review, than under the current system. And since the uninsured and the recipients of long-term care would be covered, it would, of course, mean more bill processing and review for the companies.

And finally, a national health plan should be totally self-financed through a funding package reflecting much of how we pay for care now. Funding should include the savings generated by indexed, prospective payment, and capitation; an expanded cigarette tax; extension of the Medicare payroll tax to all incomes; a premium paid by the elderly, which is approximately the same as a premium paid for Medicare today; an employer tax, based on compensation, which exists today; State revenues covering one-half the cost of the poor; and then finally a surcharge on corporate and individual income taxes sufficient for the solvency of the national health program.

Now, Mr. Chairman, I've already said what the Commission should do. The truth of the matter is, that the USHealth Act (H.R. 2980) has all of these provisions. Since a broad-based problem exists, only a broad-based solution will provide the full health and long-term care protection which Americans desperately require. This is one man's opinion and it's something I'd like to present to the Commission for your review. And not only that, but feel free to fix what needs to be fixed in this legislation. I think that it can serve as, perhaps, a guide.

Unfortunately, there is no shortage of options for dealing with this broad and tragic problem. It is also important to remember that all options get their funding from the same source, the pockets of the American people, though payment may be made through premiums, out-of-pocket, deferred wages, and so forth, it nevertheless comes out of the pockets of the American people.

Now, given the forces of change and the burdens of cost and the inequities of access, this Congress and this administration should now make a commitment to protect the uninsured and underinsured. The risk to the underinsured and uninsured is great and it grows daily, Mr. Chairman, as you have already stated. If not controlled, soon health costs will outdistance everyone's ability to pay for needed health care. We can no longer afford not to act.

Now, Mr. Chairman, with your permission——

Chairman **Rockefeller**. Mr. Chairman?

Representative **Roybal**. Yes.

Chairman **Rockefeller**. If I might, for everybody else, other than you because of you're the Chairman who succeeded Claude Pepper, there will be a 5-minute time limit.

Representative **Roybal**. All right. I will conclude then, Mr. Chairman, by offering to submit to you House bill 2980. You probably have already looked at it. You probably know what's in it. But nevertheless, I would like to officially present this to this Commission for your review. I sincerely hope that you can not only review it, but make additions and corrections. It is not something that is perfect. You see, we have a great country, but our greatness has not been reflected in what we can do for the health care of the American people. I think it is the mandate of this Commission to do that, and I know that you'll provide an answer.

I want to thank you, Mr. Chairman, for this opportunity and wish you well, for I know that you and members of this Commission will definitely respond to that mandate of the Pepper Commission when it was established. I thank you and every one of the members of this Commission.

[The prepared statement of Representative Roybal follows:]

EDWARD R. ROYBAL, CHAIRMAN
House Select Committee on Aging and its
Subcommittee on Health and Long Term Care

TESTIMONY

on

THE "USHEALTH ACT" H.R. 2980

before the

U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

9:00 a.m., Tuesday, October 24, 1989

I am here today to join forces with the Commission and to help move forward an agenda of providing affordable and quality protection to the many millions of uninsured and underinsured Americans. One of the many vehicles that can be used to accomplish this is my national health plan proposal, the "USHealth Act" (H.R. 2980).

As the member who worked with Claude Pepper on the enabling legislation that established this historic Commission, I want you to know that the challenge facing you is great. But I have great faith in your potential to meet the mandate of Section 402 which states that:

> "the Commission shall make specific recommendations to the Congress respecting Federal programs, policies and financing needed to assure the availability of (A) comprehensive long-term care services for the elderly and disabled, (B) comprehensive health care services for the elderly and disabled, and (C) comprehensive health care services for all individuals in the United States."

That last mandate, to go beyond long term care and the elderly and disabled, was specifically added at my request.

As compared to just a few years ago, you fortunately have several comprehensive reform options available for consideration. In choosing among these options, I believe that certain criteria should be applied:

- Are the uninsured fully insured?
- Are the underinsured insured for basic health care?
- Are the underinsured insured for catastrophic acute care?
- Are the underinsured insured for catastrophic long term care?
- Is the quality of health care assured?
- Are costs affordable for individuals, government and employers?

As mandated in your enabling legislation, yours is the Bipartisan Commission on Comprehensive Health Care. In my view, the Commission cannot discharge its responsibility with anything less than a comprehensive plan. Not just for the poor or the rich or the elderly, your recommendation must provide comprehensive protection for all Americans. Not just physician and hospital care, your recommendation must provide comprehensive health and long term care. Not just for certain States, your recommendation must provide comprehensive nationwide protection.

Though some argue for piecemeal or partial solutions to these problems, Congress should support a comprehensive solution. The Medicare Catastrophic Coverage Act is one example of a piecemeal approach. The failure of either business or government by itself to contain health care costs is another argument against piecemeal approaches.

It is my opinion that your recommendation should expand Medicare to provide basic health and long term care benefits for all Americans, regardless of age or income. The bill should cover primary, acute and long term care with special safeguards for catastrophic illnesses. As a tradeoff to secure this protection, it should set a national health and long term care expenditure cap.

Even in this time of tight budgets, Congress needs to take on this most difficult issue. The House Committee on Aging, as well as other committees, has held major hearings documenting two critical access deficiencies. First is the large number of Americans without any health insurance coverage -- 31-37 million people are uninsured.

The fundamental right of every American to access necessary health care can no longer be denied. We can no longer ignore the 31-37 million fellow Americans lacking insurance for either basic or catastrophic health care.

The second great deficiency is underinsurance, inadequate coverage for primary, acute, and long term care. Young families are more and more likely to be working for employers who provide no or only minimal coverage. Over 200 million Americans are without long term care protection -- be it public or private -- and are at major risk of financial disaster when hit by a catastrophic, chronic illness.

Americans find it unacceptable that those underinsured for long term care not only face the tragedy of severe long term care illness, but face a second tragedy -- a financial disaster striking both young and old. We can no longer ignore our nation's need for protection from and thus coverage for long term care costs.

A national health plan should build on the base of the Medicare program and ensure that all Americans be entitled to basic and catastrophic health insurance as well as comprehensive, flexible, managed and cost-capped long term care coverage.

You must prepare a comprehensive, national health plan, one that dismantles existing financial barriers to health care, slows the nation's escalating health care costs and improves health care quality. Also, the plan should take the unprecedented step of imposing a health and long term care cost cap at 12 percent of the Gross National Product.

Without such an approach, the Nation's health costs are projected to reach as high as 15 percent of the GNP by the year 2000. Yet, despite this enormous national investment, we would still not have resolved the crisis facing people with catastrophic illness and people without adequate health insurance protection. Setting a national health and long term care expenditure cap is a fair tradeoff to secure comprehensive protection for all Americans.

Your recommendation should include a carefully articulated system for providing long term care protection. Long term care expenditures should be capped at 1.1 percent of GNP and managed through a care management system which ensures that beneficiaries receive the care they need and that taxpayers will not face increases in costs beyond increases in their ability to pay. Further, long term care benefits should be flexible to best match beneficiary needs and promote beneficiary independence.

In the interests of making people aware of the cost of health care, cost sharing should be required on 20 percent of medical and skilled nursing home care and 25 percent of non-skilled long term care. This cost sharing should be capped by the catastrophic limits which are $600 per person per year for medical and skilled nursing care and $1,000 per person per year for non-skilled long term care.

Health care providers should be paid prospectively based on DRGs (Diagnostic Related Groupings) for hospitals and relative value scales for physician care. These fees should be developed in consultation with representatives of health care providers and indexed (to increases in per capita GNP) to our Nation's ability to pay.

This Commission must recommend legislation that brings about critically needed improvements without disrupting the essential professional and personal relationship between individual patients and their health care providers. Patient and health care provider "freedom of choice" should be preserved. Patients should be free to continue their relationship with their existing physician or hospital and free to choose among fee-for-service or capitation providers. Health care providers of all types should be included, including public providers and private profit and not-for-profit providers.

Further, this Commission's recommendation should create a special partnership with the Nation's insurance industry which protects the financial viability of those companies while ensuring comprehensive coverage for every American. It should give the insurance companies a valuable role through contracts for a much larger volume of bill processing and review than under the current system, since the uninsured and recipients of long term care would be covered.

Finally, a national health plan should be totally self-financed through a funding package reflecting much of how we pay for care now. Funding should include:
* the savings generated by indexed prospective payment and capitation, beneficiary cost-sharing,
* an expanded cigarette tax,
* extension of the Medicare payroll tax to all incomes,
* a premium paid by the elderly (approximating the "Medicare premiums"),
* an employer tax based on compensation,
* State revenues covering 1/2 the cost of the poor, and
* a surcharge on corporate and individual income taxes sufficient for the solvency of the national health plan.

USHealth (H.R. 2980) has all of these provisions. Since a broad-based problem exists, only a broad-based solution will provide the full health and long term care protection which Americans desperately require.

Fortunately, there is no shortage of options for dealing with this broad and tragic problem. It is also important to remember that all options get their funding from the same source, the pockets of the American people, though payment may be made through premiums, out-of-pocket, deferred wages (through employers), or taxes. The criteria for selecting a solution should be solely on what is the most efficient and effective way to use the American people's dollars to meet the American people's health and long term care needs.

Given the forces of change, the burdens of cost, and the inequities of access, the 101st Congress and the Bush Administration should make the commitment to protect the uninsured and underinsured. The risk to the uninsured and underinsured is great and grows daily. If not controlled soon, health costs will outdistance everyone's ability to pay for needed health care. We no longer can afford not to act.

Mr. Chairman, with your permission, I would like to submit materials on the USHealth Act (H.R. 2980) for the Commission's record. This is my recommendation for building a truly American health care system, but is surely not the only answer. It is up to this Commission to make the final decision but I am confident that the USHealth Act (H.R. 2980) will be helpful to you in the enactment of your own comprehensive recommendation to the Congress of the United States.

USHealth An American Healthplan

EDWARD R. ROYBAL
Chairman, House Select Committee on Aging

THE "USHEALTH" PROGRAM ACT: AN AMERICAN HEALTHPLAN
(H.R. 2980)

A Bill to Contain Health Care Costs,
Maintain Quality and Ensure Access for All Americans

PURPOSE

Introduced by Representative Edward R. Roybal, this legislation, using the existing Medicare program as the foundation, is designed to control health care costs for all Americans whether they be individuals, employers, or the government; to maintain health care quality for all providers and patients, and to ensure financial access to health care and prevent financial disaster resulting from catastrophic illnesses.

BACKGROUND

From 1980 through 1987, health care costs rose at an average rate of 10.4 percent, or 3.3 percent faster than the Gross National Product. Health care costs continue to rise and are likely to reach a level of 13 percent of GNP by 1995 and nearly 15 percent by the year 2000. At the same time, the elderly are paying more and more of their limited incomes for health care even with the help of Medicare and Medicaid. Out-of-pockets costs are estimated to be as high as 18.1 percent of the elderly's income in 1988 -- substantially more than the 12.7 percent level of 1980 and the 15 percent level the Medicare and Medicaid programs began. On top of the elderly's growing financial burden and in spite of the enactment of Medicare and Medicaid, 37 million poor and near poor Americans still face major access problems due to lack of insurance. At the same time, over 200 million Americans -- about 85 percent of Americans -- are underinsured against catastrophic long term illness.

BILL OVERVIEW

The provisions of this bill establish the USHealth program in 1994 which is designed to contain costs while maintaining quality and ensuring access for all Americans. Health care cost increases will more closely match the increase in per capita Gross National Product -- a level which approximates the Nation's ability to pay. The provisions to ensure financial access for all Americans, including the poor, the unemployed, the uninsured, and the elderly are financed through the savings generated by the cost containment provisions, extension of the Medicare payroll tax to all incomes, beneficiary cost-sharing, an employer tax, an expanded cigarette tax, State revenues, a premium paid by the elderly approximating the "Medicare premium", and a surcharge on corporate and individual income taxes. The provisions to maintain quality include the active involvement of providers and consumers, the current Medicare quality assurance system (including Peer Review Organizations), qualified state quality assurance programs, a national Council on Quality Assurance, and the qualification of Health Maintenance Organizations.

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BILL SUMMARY

THE USHEALTH PROGRAM. The "USHealth Program Act," using the existing Medicare program as the foundation, is designed to control health and long term care costs for all Americans whether they be individuals, employers or the government; to maintain quality of care for all providers and patients; and to ensure financial access to health and long term care and prevent financial disaster resulting from catastrophic illness for all Americans.

Cost Containment. The cost containment program covers all services and patients. The cost containment provisions include paying all health care providers prospectively where payments are developed in consultation with providers. Future increases are limited to increases in the per capita GNP. States may set up alternative payment programs.

Cost sharing of 20% for health and skilled long term care and 25% for non-skilled long term care is required, but only up to the catastrophic limits described below. Cost sharing is optional for qualified HMOs. The poor (under 100% poverty) and those spending down into poverty are exempt from any cost sharing which prevents access to needed care.

The ceiling on total U.S. health costs is 12 percent of GNP under USHealth. Under that ceiling is a ceiling on long term care costs set at 1.1 percent of GNP indexed to changes in severity, ADL (Assistance with Daily Living) levels and cognitive impairment levels.

Access. Financial access is ensured by making every citizen and permanent resident eligible.

Benefits. Beneficiaries are protected from the cost of catastrophic illness. Their financial risk is limited to paying coinsurance as follows: a. 20 percent of health care and skilled nursing home and home health costs up to a maximum of $600 per person per year (indexed to per captia GNP), and b. 25 percent of long term care costs up to a maximum of $1,000 per person per year (indexed to per capita GNP).

The basic health and long term care benefits includes standard Medicare covered services as well as the following: inpatient hospital and inpatient psychiatric hospital services, medical and other health services, comprehensive outpatient rehabilitation facility services, health care services of a medical care access facility (Effective 1/1/90), extended care and nursing facility services, skilled home health services, hospice, alcohol and drug abuse rehabilitation, and outpatient mental health services (including community mental health centers and state-authorized services provided by a clinical psychologist, clinical social worker, or psychiatric nurse specialist). In addition to the services traditionally covered by Medicare, medical and other health services are expanded to include: nurse practitioner and clinical nurse specialist services (Effective 1/1/90), EPSDT (for those under age 21), family planning (individuals of child-bearing age), private duty nursing services, physical therapy, occupational therapy, speech-language therapy/pathology, audiology, and other medical or remedial care recognized under State law and specified by the USHealth program. Dental services, (including dentures), and eyeglasses are added before the year 2000 unless total USHealth expenditures would exceed 12 percent of GNP. As under Medicare, prescription drugs are covered but the annual deductible is reduced to $100. USHealth also covers physical checkups, health screening, immunizations, health risk reduction, and other preventive services.

More specifically, long term care (LTC) benefits are covered for chronically ill individuals (at least 2 age-appropriate ADL's or a similar level of cognitive impairment). Long term care benefits include: care management services, nursing care, services of a homemaker/home health aide, medical social services, medical supplies, physical/occupational/speech/respiratory/corrective therapy, patient and caregiver education/training/counseling, day health care, respite care (minimum of 120 hours/year if eligible), nursing facility services (as under the current Medicaid program), and limited transportation. Other long term care services, including personal care, may be covered if authorized by the care management agency and if total costs do not exceed expected cost.

Quality. The current Medicare quality assurance system, including Peer Review Organizations (PRO), is upgraded to place at least as much emphasis on quality assurance as on cost containment, cover all health care providers and consumers, cover all health services (hospital, physician, nursing home, home health), set up a national Council on Quality Assurance, add Consumer Boards to PROs, establish a patient bill of rights and create an ombudsman program. States have the option to develop their own qualified quality assurance system. Quality assurance is also addressed by federal HMO qualification.

Administration. The program is entitled "USHealth" and is managed by the USHealth Administration (thus replacing the current Health Care Financing Administration); the USHealth Program is independent and off-budget. Most bill processing and review will be provided through contracts with private insurance companies.

Financing. Health care cost increases will closely match increases in per capita GNP -- approximating the Nation's ability to pay. The provisions to ensure financial access for all Americans are financed as follows: the savings generated by indexed prospective payment and capitation, beneficiary cost-sharing, an expanded cigarette tax, extension of the Medicare payroll tax to all incomes, a premium paid by the elderly (approximating the "Medicare premiums"), an employer tax based on compensation, State revenues covering 1/2 the cost of the poor, and a surcharge on corporate and individual income taxes sufficient for the solvency of USHealth.

TRANSITION AND SYSTEM-BUILDING PROVISIONS. During the interim period between enactment of USHealth and 1994 (the first year of full implementation), the bill makes several changes which provide interim protection (e.g., extending Medicaid to cover the poor),and set up the transition to USHealth (e.g., conducting studies of prospective payment), and building up the health care system (e.g., developing rural and mental health care resources).

Medicaid Expansion. Over a three-year period, Medicaid protection is expanded to cover all persons with income at or below the Federal poverty level.

Private Insurance Deduction. Small businesses and self-employed individuals are allowed to deduct the total cost of their health insurance until USHealth is implemented.

Rural Health Care Development. Several provisions improve health care in rural areas by improving payment to rural health care providers, covering cost of Medical Care Access Facilities (MedCAF), authorizing a rural health services block grant, grants to develop medical practices, and ensuring that mental health services reach rural areas.

Direct Reimbursement of Nurse Specialists. As in the previous section for Medicare/USHealth, nurse practitioners and nurse specialists are covered by Medicaid.

Health Care Personnel Development. In order to better assure the availability of appropriate health care personnel, the bill expands the National Health Service Corps, establishes a Rural and Urban Health Assistance scholarship and loan repayment program, provides training funds, and expands the Area Health Education Centers.

Mental Health Care Development. Several provisions are designed to improve mental health care by funding research and demonstration projects, upgrading quality assurance and program effectiveness review and methodologies, requiring Medicaid coverage of mental health care, and changing the provision ensuring appropriate mental health care in nursing homes.

Alzheimer's Assistance Development. With respect to Alzheimer's, the bill creates and authorizes funding for State Alzheimer's programs. It also requires the Secretary to take several actions to assure adequate payment, quality of care, and access for Alzheimer's patients.

Community and Migrant Health Centers Expansion. As one way to reach underserved populations, the bill expands funding for community and migrant health centers by 10 percent.

THE "USHEALTH" PROGRAM ACT—BILL DESCRIPTION

In attempt to deal with the problems facing the American health care system, a series of changes are proposed. The provisions of this bill, if enacted, extensively modify the existing Medicare program in order to establish the USHealth program . This program contains health care costs for the federal government, States, employers, and consumers, improves financial access to needed services, helps maintain quality, and increases equity among health care providers and payers. The following reforms take full effect in 1994.

DIVISION A. USHEALTH PROGRAM.*

Title I. Eligibility and Enrollment.

Sec. 1101. Eligibility and enrollment. All U.S. citizens and permanent residents are eligible for the USHealth program. Enrollment in the USHealth Program is through the issuance of an account number either at time of birth or when issued a Social Security number.

Title II. Benefits and Providers.

Sec. 1201. Description of benefits. Sec. 1202. Changes in exclusions. Sec. 1203. Standards for certification of certain services. As of 1994, the basic health and long term care benefits package for all enrollees includes standard Medicare covered services as well as the following: inpatient hospital and inpatient psychiatric hospital services, medical and other health services, comprehensive outpatient rehabilitation facility services, health care services of a medical care access facility (Effective 1/1/90) (RUR), extended care and nursing facility services, skilled home health services, hospice, long term care for a chronically ill individual (LTC), alcohol and drug abuse rehabilitation, and outpatient mental health (Effective 1/1/90, including community mental health centers and state-authorized services provided by a clinical psychologist, clinical social worker, or psychiatric nurse specialist) (MH).

In addition to the services traditionally covered by Medicare, medical and other health services are expanded to include nurse practitioner and clinical nurse specialist services (Effective 1/1/90) (NRS), EPSDT (for those under age 21), family planning (individuals of child bearing age), private duty nursing services, physical therapy, occupational therapy, speech-language therapy/pathology, audiology, and other medical or remedial care recognized under State law and specified by the USHealth program. Dental services, (including dentures), and eyeglasses are added before the year 2000 unless total USHealth expenditures would exceed 12 percent of GNP. Mental health services are covered as under Medicare but the USHealth Board is to replace the current (Medicare) mental health limits on payments and covered services with an alternative system which better ensures access but contains costs. Medicare's outpatient mental health benefit limit is changed to 20 visits annually (which may be increased if necessary) and to not count mental health related medical management visits toward the limit (Effective 1/1/90) (MH). As under Medicare, prescription drugs are covered but the annual deductible is reduced to $100. USHealth also covers physical checkups, health screening, immunizations, health risk reduction, and other preventive services.

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* Certain provisions take effect for Medicare during the transition period prior to 1994 and are so noted with an earlier effective date.

More specifically, long term care benefits are covered for chronically ill individuals (at least 2 age-appropriate ADL's or a similar level of cognitive impairment). Long term care benefits include: care management services, nursing care, services of a homemaker/home health aide, medical social services, physical/occupational/speech/respiratory/corrective therapy, medical supplies, patient and caregiver education/training/counseling, day health care, respite care (minimum of 120 hours/year if eligible), nursing facility services (as under the current Medicaid program), and limited transportation. Other long term care services, including personal care, may be covered if authorized by the care management agency and if total costs do not exceed expected costs. Care management agencies are to be State agencies, except where not available, and are to carry out the assessment, develop a plan of care, and manage that plan of care. Full coverage is provided with the copayments made to the Trust Fund. The copayment is waived for low income and for spend-down individuals. As part of the long term care benefit package, incentives are to be developed to encourage families to keep a LTC family member in their home. Strong utilization review is instituted by PROs and intermediaries/carriers to control costs. (LTC)

(See Section 1401.) Beneficiaries are protected from the cost of catastrophic illness but are required to pay coinsurance as follows: a. up to a maximum of $600 per person per year (indexed to per capita GNP) for health care and skilled nursing home and home health costs, and b. up to a maximum of $1,000 per person per year (indexed to per capita GNP) for non-skilled long term care costs.

Sec. 1204 (RUR) Development of Medical Care Access Facilities (MedCAF). Makes rural health care transition funds available for developing MedCAFs and expands the Rural Health Care Transition Fund to $45,000,000 by 1992. MedCAF (Medical Care Access Facility) is a facility which provides ambulatory, primary, emergency, urgent, and surgical care, provides basic inpatient care with up to 10 inpatient beds, and provides ancillary services including radiology and laboratory in frontier areas with populations between 1,000 and 5,000. The Secretary of the Department of Health and Human Services may waive the minimum and maximum populations qualifying for MedCAF designation when the geographic area is similar in character to MedCAF areas defined above. The maximum number of days allowed per hospital stay is 2 days (48 hours) with an exception process, through the Peer Review Organizations (PROs), allowing for additional days. Each MedCAF is required to have an approved quality assurance plan. (See detailed description in National Rural Health Care Act, H.R. 950).

Sec. 1205. (RUR) Rural Health Clinic demonstration program. Creates a rural health clinic demonstration program similar to the existing rural health clinic program but which allows use of a prospectively set fee schedule, covers preventive health services, and changes the minimum PA/NP time to 40 percent of clinic time.

Sec. 1206. (RUR) Rural and central city health care research and demonstrations. Provides for demonstration/waiver projects as to how to better cover rural and central city health care under Medicare and Medicaid.

Sec. 1207. Miscellaneous conforming and technical amendments. The bill treats Medical Care Access Facilities as a provider of services, adds long term care management agencies as a covered provider, and requires that long term home care services and acute home health services be coordinated so that receipt of long term home care not affect coverage for acute home health care. (RUR) (LTC).

Title III. Payments for Services.

Sec. 1301. Limiting rate of increase of all payment amounts. This bill incorporates a series of cost containment measures to keep total costs to no more than 12 percent of the Gross National Product and, in general, to keep long term care costs to no more than 1.1 percent of the Gross National Product. Greater incentives are provided for Health Maintenance Organizations. States are allowed and encouraged to implement state-wide cost containment programs as long as they perform as well as the federal program.

The USHealth Board makes adjustments in provider payments as necessary to maintain total program costs under 12 percent of GNP while ensuring that benefits are not reduced and out-of-pocket costs are not increased more than under current USHealth Program law. The "GNP" index is based on a 3-year moving average of increases in per capita GNP.

With respect to long term care, the USHealth Board makes other adjustments in long term care provider payments and the maximum monthly benefit for non-institutional care as necessary to maintain total long term care costs under 1.1 percent while ensuring that benefits are not reduced and out-of-pocket costs are not increased more than under the USHealth Program law as enacted initially. The ceiling of 1.1 percent is indexed to the changes in the U.S. population meeting the ADL and cognitive impairment standards and to changes in severity and resulting resource needs. At the State and local level, the care management agencies manage the authorized payment level for their clients. The maximum monthly benefit for noninstitutional care is limited to 95 percent of the expected cost if the chronically ill individual were in an extended care facility. (LTC).

Sec. 1302. Payments for inpatient hospital services. As of 1994, all inpatient hospital care is paid using Medicare's prospective payment system using the Diagnostic Related Groupings and adjusted for population differences (for example, based on a case severity or complexity index). Future hospital prospective payment rate increases are limited to increases in per capita Gross National Product as described in the cost containment section above. Capital is no longer allowed as a pass-through and is added to the DRG payment. The adjustment to a particular DRG payment reflects the amount of capital required for that DRG. The mean ratio of total capital outlays to total non-capital DRG payments is not to exceed the mean ratio for the most recent three years. Medical education is paid on the same basis as under current Medicare law.

Sec. 1303. Payments for other services. As of 1994, a fixed, prospective fee schedule is used to pay all providers in full for all non-hospital services (including medical, nursing home, home health, drugs, and laboratory). The fee schedule is developed by the USHealth Administration in consultation with the respective provider organizations (e.g., nurse practitioner and nurse specialty groups) and consumer groups. With respect to direct reimbursement of nursing services, a hot-line is set up to handle inquiries (NRS). In designing the fee schedule, adjustments should be made for differences in patient population, service type, and the "cost-of-doing-business", including resource inputs and input prices (e.g., malpractice insurance). For example, physician payments should address current inequities among geographic areas, physician specialties, and types of service. To the extent possible and appropriate, the fee schedule should reward higher quality providers. For comparison purposes, the mean weighted fee cannot exceed the mean fee for a similar service paid under the current Medicare system as amended by this Act. Except for adjustments to reflect service delivery changes, future fee increases are limited to no more than increases in per capita Gross National Product. Such increases may be adjusted to reflect changes in service delivery and billing practices.

Subject to guidelines established by the USHealth Board, all licensed individual health care practitioners may be reimbursed as health care providers.

Utilization review of all health and long term care services is conducted by the Peer Review Organizations and by insurance companies functioning as intermediaries/carriers. Intermediary/carrier review is strengthened to better control changes in billing practices, service volume, site of service delivery and service intensity.

Payments to all providers are to be adjusted as necessary to ensure reasonable availability of health care services in rural areas, central city areas and for other "special need" areas or populations.

States have the option to be exempt from the federal system and to implement their own alternative payment programs. In order to qualify for the exemption, the state program must meet or exceed the cost containment targets entailed in this bill and maintain access and quality equal to or exceeding the levels resulting from this bill. The alternative payment system must be mandatory for and equitably treat all types of providers covered under the State system.

For each State wishing to develop acceptable alternative payment programs, the federal government provides a three year development grant totaling between $1 million and $3 million. Those States with acceptable programs are eligible to have up to 50 percent of the savings (as compared to what would have paid under this amended law) added to reduce the state payment for the poor beginning in 1994. No additional state funds are needed to match this latter allocation.

Medical Care Access Facilities (MedCAF) are to be paid based on the type of service provided whether it be an inpatient service (DRG payment), emergency service (a combined professional and facility payment), or ambulatory care and other services (prospectively set fee based on relative value), (Effective 1/1/90) (RUR).

Sec. 1304. Direct payment for all services and use of intermediaries. As of 1994, the approved health care provider fee is full payment and is paid directly to the health care provider by USHealth. USHealth collects any coinsurance from the beneficiary.

In general, USHealth, as does Medicare, uses intermediaries and carriers to process health care provider claims and, to the maximum extent practicable, insurance companies are to be used as carriers.

Sec. 1305. Changes in HMO coverage and payment. HMOs are major providers of health care for beneficiaries. The USHealth Administration shall require participating HMOs (including HMOs, CMPs, and IPAs) to be qualified as specified under Title XIII of the Public Health Service Act beginning in 1994. HMOs must continue to be qualified on an annual basis. HMOs shall be penalized or removed from the program when they do not meet the HMO qualification standards. The Office of Health Maintenance Organization's cost for carrying out the ongoing qualification process is covered by the Trust Fund. Quality assurance review for HMOs is conducted by the Peer Review Organizations conducting review on non-HMO services.

As of 1994, the payment for HMOs is raised from 95 percent of the Average Area Per Capita rate (AAPC) to 100 percent of AAPC. The AAPC is adjusted by age, sex, enrollee type, and appropriate health status factors.

Publications are provided which give side-by-side comparisons of HMOs in each area of the country. The use of HMOs is promoted, including the provision of a comparison of HMOs with the non-HMO providers in terms of quality assurance, covered services, and out-of-pocket costs to the elderly and disabled.

Title IV. Financing Program.

In order to finance the USHealth program and to provide an orderly transition from the current system of financing health care, USHealth is financed through the revenue sources listed below. Much of the long term cost of expanding access and reducing costs for all beneficiaries comes from reducing health care cost inflation for all payers and for all health care providers. Health care costs savings are expanded by holding cost increases down to per capita growth in GNP and by controlling utilization. Beneficiary cost-sharing applies to all services but is limited by the catastrophic provisions.

Sec. 1401. Limited coinsurance and copayments with protection against catastrophic expenses. Beneficiaries are protected from the cost of catastrophic illness but do contribute to the financing of USHealth by paying coinsurance as follows:

a. 20 percent of health care and skilled nursing home and home health costs up to a maximum of $600 per person per year (indexed to per capita GNP), and
b. 25 percent of long term care costs up to a maximum of $1,000 per person per year (indexed to per capita GNP).

The above coinsurance provision is waived for individuals in families with incomes under the poverty level and for individuals whose health care costs require the family to spend down below the poverty level. However, a nominal copayment may be charged to the poor as long as it does not prevent access to needed health care.

Coinsurance payments are collected by USHealth for the beneficiary and made directly to the Trust Fund. The failure to make payments does not result in a loss of the entitlement but USHealth will pursue payment where appropriate.

Sec. 1402. Extension of hospital insurance tax to all wages. The "Medicare payroll tax" is expanded to cover all income levels. (Effective 1/1/90).

Sec. 1403. Elimination of Part B Medicare premiums for disabled beneficiaries and phase-out of Part B Medicare premiums for elderly beneficiaries. The Medicare Part B premium is eliminated for disabled beneficiaries. The Part B premiums (regular and catastrophic) for elderly beneficiaries is phased out beginning in the year 2000 by reducing it by 20 percent until it is eliminated in the year 2004. The premium is waived for elderly beneficiaries who are under the federal poverty level.

Sec. 1404. Changes in Medicare supplemental premium. Beginning with the year 1994, the Medicare supplemental income-related premium (Medicare Catastrophic Coverage Act) rate is frozen and is subsequently reduced by $4 each year until it is phased out completely in the year 2005. The limit on the premium is indexed to the growth in per capita GNP until the premium is phased out.

Sec. 1405. Excise tax on wages and self-employment income. Employers pay a tax based on a percentage of employee compensation. The basis for setting that percentage is the aggregate amount which employers are paying under the current system for employee and retiree health benefits in 1988.

Sec. 1406. Increase in federal excise tax on cigarettes. The cigarette excise tax is raised by 16¢ and indexed to per capita GNP. (Effective 1/1/90).

Sec. 1407. State contributions. States provide contributed revenues equal on average to one-half of the cost of the poor (i.e., everyone under the Federal poverty level). Payment formula is as follows: (total national cost of poor) X 1/2 X (State population/US population) X (State per capita income/National per capita income).

Sec. 1408. Tax surcharge on all taxpayers. An earmarked surcharge on all corporate and personal income taxes is made which equals the amount necessary to maintain the solvency of the USHealth Trust Fund. The financing formula is as follows: total USHealth expenditures minus cost sharing minus cost savings minus State share minus cigarette add-on minus the "Medicare payroll tax" minus the employer tax minus other revenue additions = Net revenue required from an X% surcharge on Federal corporate and individual income tax.)

Sec. 1409. USHealth Program Trust Fund. Revenues are placed in the USHealth Trust Fund which is off-budget. The law requires USHealth to be self-funding and prohibits the transfer of funds from general revenues into USHealth and from USHealth into the general fund of the Treasury. Within 6 years, the Trust Fund should have an appropriate reserve for contingencies.

Sec. 1410. Repeal of exclusion from income of employer health insurance contributions. Employers would no longer be able to exclude employer health insurance contributions from their taxable income.

Title V. Quality Assurance.

The current Medicare quality assurance (QA) system, which includes Peer Review Organizations and nursing home quality assurance is upgraded to cover all medical services (inpatient and outpatient) for all patients and all providers and to place at least as much emphasis on quality assurance as on cost containment. Most provisions are to be phased in as of January 1, 1993. A State has the option to obtain a waiver from this requirement if it establishes its own plan of quality assurance and as long as it provides at least the same level of protection as the amended federal plan.

Sec. 1501. National Council on Quality Assurance. This bill establishes a national Council on Quality Assurance (CQA) to provide oversight on the operations of the quality assurance system and make recommendations to DHHS and, subsequently, the USHealth Administration and to the Congress for its improvement. Its oversight function includes the review of the administration of quality assurance, the overall performance of the PROs and waivered state plans, reports of the Consumer Boards, quality assurance studies and methodologies developed by DHHS, the USHealth Administration and others, the data needs of the PROs, and input from interested parties.

DHHS and, subsequently, the USHealth Administration are required to provide such information as is needed by CQA to carry out its responsibilities. Based upon these reviews, the Council is to make recommendations annually for improving quality assurance to DHHS and, subsequently, the USHealth Administration and to the Congress. DHHS and, subsequently the USHealth Administration are required to take into account CQA input in its administration of the PRO program.

The Congressional Office of Technology Assessment (OTA) will provide for the appointment of the fifteen member Council consisting of equal numbers of health care providers, health care consumers, and experts in quality assurance. Subject to the review by OTA, the Council may employ staff as necessary to carry out these functions.

Sec. 1502. Emphasis by peer review organizations on quality assurance. This bill requires DHHS and, subsequently, the USHealth Administration to award, administer, and evaluate its PRO contracts under the stipulation that at least one-half of the PROs' level of effort is for the purpose of quality assurance as of January 1, 1990.

This bill requires that health and home care agencies have plan of care policies which identify services to be provided, provide a means for identifying additional client needs, and include coordination mechanisms with other service agencies.

Sec. 1503. Extension of quality assurance to all services (Effective 1/1/90). This bill requires the DHHS and, subsequently, the USHealth Administration and its contract PROs to conduct quality assurance for all patients. This bill requires the DHHS and, subsequently, the USHealth Administration and its contract PROs to conduct quality assurance activities on all medical providers including hospitals, physician offices, nursing homes, home health agencies, hospices, nurse practitioner and nurse specialty services (NRS), and HMOs and other alternative delivery systems. The level of PRO effort expended on each type of provider reflects the proportion of national health care expenditures for this type of provider and the need for review. Similarly, membership on the PRO governing body and its composition reflect the range of health care providers reviewed by the PRO.

Sec. 1504. Consumer boards. This bill requires each PRO to have a Consumer Board (CB) which conducts ongoing oversight of the PROs, provides input into the award and evaluation of PRO contracts, and can receive input from Medicare beneficiaries and other interested parties. The CB and the PRO are responsible for educating consumers on quality assurance and on the availability of assistance from the PRO and other agencies. The PRO makes available to the CB such information and staff as are necessary to carry out the CB function. This does not include information where either the individual health care provider or consumer can be identified.

The CB is required to prepare an annual report on the PRO's performance and submit that report to the respective Governor(s), to the national Council on Quality Assurance, and to DHHS and, subsequently, the USHealth Administration. CB input is to be utilized in decisions to award PRO contracts.

The CB consists of 5-7 volunteer members appointed by the respective Governor of the State covered by the PRO and representing organizations of the elderly, the disabled, the poor and other consumers. In addition to the CB, each PRO has at least one health consumer, who is not a health care provider, on its Board of Directors.

Sec. 1505. Quality assurance hot-line. This bill requires PROs to have a 7-day-a-week hot-line for receiving questions and complaints from health care providers, consumers, and interested parties concerning health care quality problems. PROs are required to assist in the resolution of any legitimate quality related problems. The USHealth Administration, in coordination with each PRO, shall provide beneficiaries with the hot-line number for their PRO in a way that can be easily attached to their USHealth cards. The PRO hot-line is coordinated with the hot-lines operated by the Ombudsman program and any State quality assurance programs.

Sec. 1506. Funding of increased activities. As compared to current law and adjusted for inflation, the funding level for the PRO program is increased by 50 percent in FY 1994 (first year of implementation), by 65 percent in FY 1995, and by 75 percent in FY 1996 and in subsequent years. The funding for the CQA and the PROs program will be made from the Trust Fund. For those States with their own federally qualified quality assurance plans, the USHealth Administration is authorized to make available funds up to the amount that would have gone to the respective PRO as authorized above.

Sec. 1507. (LTC), Assuring quality of care management and home care services. This bill sets home care and care management quality assurance standards and required compliance as a condition of participation under USHealth. Home health agencies are required to follow the consumer bill of rights, set up grievance procedures, assure adequate training of home care personnel, properly supervise home care providers, develop patient plans of care, and arrange for discharge/transfer. The Board may provide for a temporary waiver if access would be limited.

The requirements for long term care management agencies are somewhat similar to those for home care agencies.

The USHealth Board will arrange for periodic survey of both types of agencies. States are encouraged to develop licensing policies for home health agencies.

Training grants for home health agencies, home care providers, and long term care management agencies are authorized up to a total of $50,000,000 for FYs 1993 and 1994.

Sec. 1508. Hospital discharge planning process. (Effective 1/1/92). This bill sets guidelines for discharge planning to protect against inappropriate discharges and to ensure a smooth and timely transition to post-hospital care. It also requires that hospitals have in place a discharge planning process that begins as close to the time of hospital admission as appropriate and that alerts nursing home and home health providers of a patient's anticipated need for post-hospital care at the earliest possible time.

Sec. 1509. (MH) Assuring pre-paid organizations provide quality, accessible mental health services. (Effective 1/1/91) Prepaid health plans under Medicare are required to have quality mental health services accessible to their Medicare enrollees.

Sec. 1510. Consumers' bill of rights. This bill establishes a federal bill of rights for health care consumers under USHealth.

Sec. 1511. Health and long term care ombudsman. This bill establishes a Health and Long Term Care Ombudsman Program to investigate and resolve health and long term care provider service complaints and to provide information on health and long term care provider services. The Ombudsman hot-line is coordinated with the hot-lines operated by the PRO and any State quality assurance programs. Funding for the Health and Long Term Care Ombudsman is authorized at $55,000,000 for 1994. In each subsequent year, the amount will be the previous year's authorization increased to reflect increases in per capita GNP.

Sec. 1512. Studies and reports. The USHealth Administration shall prepare an annual report which assesses the performance of the quality assurance system and addresses the recommendations of the CQA and the concerns and recommendations of the CBs. DHHS and, subsequently, the USHealth Administration shall analyze the impact which the federal cost containment system, limitations on health care provider payments, and Health Maintenance Organizations have had on health care quality, access and beneficiary cost and submit an annual report to Congress. The USHealth Administration shall conduct studies on and develop improved methodologies for quality assessment and assurance for health care services including hospital, physician, nursing home, home health services, and hospice services. The USHealth Administration shall submit an annual report to Congress on the progress toward developing such methodologies.

Title VI. Administration and Miscellaneous.

Sec. 1601. Establishment of USHealth Program Administration as a separate, independent agency. Responsibilities of the agency. Overall administration is by the federal government's USHealth Administration (currently, the Health Care Financing Administration (HCFA)) which is both off-budget and operates as an independent agency.

USHealth is overseen by the USHealth Board. The Health Board has responsibilities for and control over the program subject to the the law or subsequent changes in the law, establishing the USHealth program. The Health Board members are appointed by the President with the consent of the Senate. The Administrator of the USHealth Administration reports to the USHealth Health Board. Within the USHealth Administration, an Ombudsman office is established to represent beneficiary interests and help resolve beneficiary problems.

USHealth replaces the current Medicare and Medicaid programs and is built upon those two programs.

Sec. 1602. Transfers to the new USHealth Administration. All functions currently carried out by the Health Care Financing Administration (HCFA) are transferred to the USHealth Administration and HCFA is abolished.

Sec. 1603. Transitional rules.

Sec. 1604. (LTC) Demonstration Projects. The Secretary is required to carry out the following demonstration projects: demonstrations of different models for care management and demonstrations of how best to cover day health care under long term care.

Sec. 1605. Effective dates of title.

Sec. 1606 Conforming amendments to the Social Security Act.

Sec. 1607. Rules of construction.

Title VII. Miscellaneous Provisions.

Sec. 1701. Repeal of Medicaid program. The Medicaid program is repealed as of January 1, 1994.

Sec. 1702. General effective date and savings provision for Medicare and Medicaid. In general, USHealth and all its provisions (unless otherwise noted) take effect as of January 1, 1994.

Sec. 1703. Additional conforming and technical amendments.

DIVISION B. TRANSITION AND SYSTEM-BUILDING PROVISIONS.

Title I. Medicaid Expansion to Cover Poor. (Sec. 2101) (RUR)

In order to ensure improved and uniform access by lower income rural and urban residents, Medicaid eligibility for "categorical" benefits is changed to cover all people whose incomes are at or below 100 percent of the Federal poverty level and whose resources do not exceed twice the SSI level. As of January 1, 1990, all children (18 or under) whose incomes are at or under the Federal poverty level are covered by Medicaid. As of January 1, 1991, all other people whose incomes are at or under 90 percent of the Federal poverty level are covered. As of January 1, 1992, all persons whose incomes are at or under 100 percent of the Federal poverty level are covered by Medicaid.

Title II. Private Health Insurance Deduction. (Sec. 2201) (RUR)

Health insurance for self-employed individuals, small businesses and farms, is fully deductible under the same rules as for larger businesses for the years 1991 through 1993. (See earlier financing section for repeal of deduction as of end of 1993).

Title III. Rural Health Care Development.

Sec. 2301. (RUR) Special Medicaid payment rules for payment for rural medical practice, rural nursing facilities, and rural home health agencies. (Effective 1/1/91-12/31/94). In setting payment rates for rural medical practices, the rates are to utilize a cost-of-doing-business adjustment, incorporating differences in physician cost, nurse cost, utilities, equipment and supplies, and capital costs, in each payment category. A provision is made for a separate adjustment on a per payment basis for providing the capability (24-hour on-call coverage and "down-time" in low volume areas). In general, the Secretary of the Department of Health and Human Services, in consultation with primary care providers and consumers, is to design an appropriate system and to reduce the differential between urban and rural physician, physician assistant, nurse practitioner, nurse, and other health personnel cost factors so as to provide a reasonable incentive to practice in rural areas.

Additional changes in payments for rural medical practices include: a) paying at the same rate for the same type of urgent/emergency visits provided at either the hospital emergency room or a physician's office while allowing hospitals to bill for the overhead costs they can currently, and b) paying for an after-office-hours phone call for the purpose of triaging patients.

Rural nursing homes are given the option to be paid on a prospectively set "daily rate" schedule, designed by the Secretary of the Department of Health and Human Services in consultation with nursing homes and consumers. The schedule varies by type of patient and is tied to a cost-of-doing-business index (e.g., index should take into account higher overhead costs and/or stand-by capability).

Home health agencies are given the option to be paid on a prospectively set "per type of visit" schedule, designed by the Secretary of the Department of Health and Human Services in consultation with home health agencies and consumers. The schedule is tied to a cost-of-doing-business index (e.g., index should take into account higher overhead costs and/or stand-by capability).

Sec. 2302. (RUR) Medicaid coverage of services of medical care access facilities. (Effective 1/1/91-12/31/94) Medical Care Access Facilities (MedCAF) can be covered under Medicaid as under the Medicare/USHealth program. (See above.)

Sec. 2303. (RUR) Placement of office of rural health care in the office of the Secretary of Health and Human Services. As of enactment, the Office of Rural Health Care is to be located in the Office of the Secretary of the Department of Health and Human Services.

Sec. 2304. (RUR) Rural health service block grant.

State Rural Health Planning Grants. Health planning grants are to be made available to States in order to develop rural health access plans. State plans are to address how federal and state program funding, (including preventive, community health services, and EMS block grants, immunization funding, occupational safety and health programs, sexually transmitted diseases funding, and the maternal and child health block grant), could better address access problems in rural areas. The formula for distributing available funds among the States is tied to ratio of non-MSA population in a State to non-MSA population in the U.S. population. The minimum for a grant is $100,000. Authorized funding is $20 million for 1990, $21 million for 1991, and $22 million for 1992.

Emergency Medical Services. A seperate rural Emergency Medical Services (EMS) block grant is established. In order to receive funding under the rural EMS block grant, the State is required to have a state rural health plan which is acceptable to the Secretary of the Department of Health and Human Services. Funding is available for start-up costs for transportation and communications and ongoing costs for uncompensated trauma care and transportation. The formula for distributing available funds among the States is tied to ratio of non-MSA population in the U.S. population. The minimum for a grant is $100,000. Authorized funding is $150 million for 1990, $156 million for 1991, and $160 million for 1992.

Sec. 2305. (RUR) Medical practice development grants. Medical Practice Development Grants for solo and group practices, rural health clinics, and MedCAFs are to be made available to increase the number of health care providers serving underserved rural areas. (MedCAF Development Grants are to be included as described earlier. See above.)

Medical Practice Development Grants - Solo and Small Group Practices. Rural Medical Practice Development Grants are to be available for solo and small group practices. These grants (for training, supplies and equipment) are for practices which increase access to primary care and provide 24-hour urgent care. They require documentation of personnel training and/or proficiency. Grantees are required to accept Medicare and Medicaid patients. Start-up grants are available up to $20,000 and may be coupled with annual grants of $1,000. (Authorizes $6 million for 1990, $7 million for 1991; $ 5 million for 1992).

Medical Practice Development Grants - Rural Health Clinics. Rural Medical Practice Development Grants are to be available for rural health clinics as well. Grants for training, supplies, and equipment are available for those which will increase access to primary care and will provide 24-hour urgent care. Clinics are required to accept both Medicare and Medicaid patients. They are also required to provide documentation of personnel training and/or proficiency. Authorized funding is $20 million for 1990, $30 million for 1991, and $30 million for 1992. Start-up grants are available as follows:

Frontier areas -- These areas are eligible for start-up grants of up to $120,000 for clinic operations (maximum of 25% of grant), training, supplies, equipment and facility. A 25% match is required from the local area or the State. Also, clinics are eligible for annual non-matching grants of $1000. Eligible sites are required to be in a frontier service area consisting of less than 6 persons per square mile and at a distance of more than one-half hour travel time from a city of 2,500.

Rural counties (non-frontier) -- These areas are eligible for start-up grants of up to $120,000 for clinic operations (maximum of 25% of grant), training, supplies, equipment, and facility. A 75% match is required from the local area or the State. Also, clinics are eligible for annual non-matching grants of $1000. Eligible sites are required to be in a small rural county, less than 20,000.

Medically Underserved Areas (MUA) -- These areas are eligible for start-up grants of up to $120,000 for clinic operations (maximum of 25% of grant), training, supplies, equipment, and facility. A 25% match is required from the local area or the State. Also, these clinics are eligible for annual non-matching grants of $1000.

Sec. 2306. (RUR) Rural health care research projects. The National Center for Health Services Research is required to commit a minimum of 5 percent of new grant projects (for fiscal years 1990, 1991, and 1992), for research relevant to improving rural delivery systems. In addition, the National Center for Health Statistics is to conduct a study on how to improve the availability of data for determining medically underserved rural areas and for monitoring changes in the health status of rural residents.

Sec. 2307. (RUR) Alcohol, drug abuse, and mental health block grant. (Effective January 1, 1990). States receiving alcohol, drug abuse and mental health block grants from the Alcohol, Drug Abuse and Mental Health Administration are required to document the mental health needs in rural areas and document State's level of effort with respect to providing mental health services in rural areas.

Sec. 2308. (RUR) National Institute of Mental Health. Funding is provided for research on rural mental health care delivery systems through the National Institute on Mental Health. Authorized funding is $5 million for 1990, $5 million for 1991, and $5 million for 1992.

Title IV. Direct Reimbursement of Nurse Specialists. (Sec. 2401) (NRS)

As with the previous Medicare/USHealth provisions, the bill provides direct Medicaid reimbursement for nurse practitioners, clincal nurse specialists, certified nurse midwives, and certified registered nurse anesthetists beginning January 1, 1991. Servicing are defined as those services covered as physician services and within the scope of state nursing practice laws. These services could include services provided in nursing homes, hospitals, patient homes, and ambulatory care settings.

Title V. Health Care Personnel Development.

Sec. 2501. (NRS) National Health Service Corps scholarship program and loan repayment program. For the National Health Service Corps, the authorized funding for scholarships and loan repayments is $15 million for 1990, $16 million for 1991, and $17 million for 1992.

Sec. 2502. (NRS) Rural and urban health assistance scholarships and loan repayments. In addition to the current National Health Service Corps, Rural and Urban Health Assistance Scholarships and loan repayments are established at an increased level from the current NHSC. A minimum of forty percent of placements (by type of student) are targeted for underserved rural areas. The percentage of total placements which are made at federal prisons is limited to one percent. Eligible sites for placements include those sites eligible under the current NHSC program, MedCAFs, rural health clinics (current and optional demonstration program), and private practices in priority underserved rural or urban areas. Scholarship students are required to serve one year in an eligible site for every year in which a full scholarship is received. Loan repayments are treated the same way as in current loan repayment programs.

Eligible students include primary care physicians (with the primary emphasis being on those in family practice), nurses, nurse practitioners, physician assistants, psychologists, clinical social workers, pharmacists, dentists, and other allied health professionals.

For the National Health Service Corps, the authorized funding for scholarships and loan repayments is $15 million for 1990, $16 million for 1991, and $17 million for 1992. (This is the same as or similar to the Rural Health Coalition Proposal.) For the Urban and Rural Health Assistance Scholarships and loan repayments the authorized funding is $15 million for 1990, $20 million for 1991, and $22 million for 1992.

Sec. 2503. (NRS) Health care personnel training programs.
Primary Care Personnel. Effective January 1, 1991, training programs (for primary care physicians, nurses, nurse practitioners, physician assistants, psychologists, clinical social workers, pharmacists, dentists, and other allied health professionals) are funded by the federal government and would be required to provide assurances that training takes into account special practice conditions of rural areas and target efforts toward students who are more likely to locate in underserved rural areas. To encourage the training of health care professional who are more likely to serve underserved rural areas, development grants are provided to health training programs (for primary care physicians, nurses, nurse practitioners, physician assistants, psychologists, clinical social workers, pharmacists, dentists, and other allied health professionals) to develop and support training programs which can best place providers in underserved rural areas. Authorized funding is $10 million for 1990, $12 million for 1991, and $13 million for 1992.

Multi-competent Technicians. New training program funding is established to train multi-competent technicians to serve in underserved rural areas. Demonstration program grants may be made to hospitals, colleges, and technical schools to develop model training programs for multi-competent technicians. Multi-competent technicians are technicians skilled by education/experience to perform limited routine laboratory procedures, including, limited radiography (chests, extremities, and abdomen) as well as cross trained as EMT I and/or II per DOT guidelines. Authorized funding is $1 million for 1990, $2 million for 1991, and $2 million for 1992.

Sec. 2504. (NRS) Area health education centers. Funding for Area Health Education Centers is increased and is to be targeted toward those health professions which are in short supply. The requirement for the number of residencies is reduced to two. Medical schools are required to provide at least a half-time tenured faculty member to serve as the director. Authorized funding is $20 million for 1990, $21 million for 1991, and $22 million for 1992.

Sec. 2505. (NRS) Continuing education for nurses in rural areas. Effective upon enactment, continuing education of nursing personnel is increased through a program to bring continuing education (e.g., via satellite transmission) to rural areas. This program is designed to offer continuing education to nurses so they will be able to maintain and upgrade their skills and to counter the sense of professional and educational isolation.

Title VI. Mental Health Care Development.

Sec. 2601. (MH) Research and demonstration projects. Biomedical, behavioral, and social research on prevention, treatment, and service delivery for mentally impaired elderly is increased. The Department of Health and Human Services is required to develop a plan of prevention, treatment, and service delivery research related to elderly mental health and psychosocial well-being and to implement it through the National Institute on Aging, the National Institute of Mental Health, and the Administration on Aging.

- Adds $8 million in FY 1990, $16 million in FY 1991, and $24 million in FY 1992 to NIMH research programs on elderly mental health. At least 10% of these funds are to be used for service delivery research.
- Adds $4 million in FY 1990, $8 million in FY 1991, and $12 million in FY 1992 to NIA's research programs on elderly mental health and psychosocial well-being. At least 10% of these funds are to be used for service delivery research.
- Adds $2 million in FY 1990, $4 million in FY 1991, and $6 million in FY 1992 to AoA's research and demonstration programs on elderly mental health.

Sec. 2602. (MH) Quality assurance and program effectiveness study. The Secretary of the Department of Health and Human Services is required to contract with the Institute of Medicine for a study of quality assurance and program effectiveness with respect to mental health services. The study is to determine methods for measuring and assuring the quality and program effectiveness of mental health services and alcohol and drug abuse treatment services as provided in various settings, including psychiatric hospitals, inpatient psychiatric units in general hospitals, nursing homes, community mental health centers, and other ambulatory care settings. The study is to develop recommendations to providers, program administrators, and payers, including Medicare and Medicaid. Funding is set at $500,000 for fiscal year 1990. The study is to be completed and a report submitted to Congress within 18 months of the signing of the contract.

Sec. 2603. (MH) Additional studies on mental health services. The Institute of Medicine is requested to conduct a study comparing mental health services, benefits, access, and quality under Medicare and non-Medicare prepaid health plans, and in settings other than prepaid plans.

Mental Health Facilities. The Secretary of Health and Human Services is directed to conduct a study examining mechanisms for ensuring quality of and access to mental health services delivered by state and local mental health facilities and by independent providers of mental health services.

Minority Access to Community Mental Health Centers. The Secretary of Health and Human Services is directed to conduct a study examining the representations of racial and ethnic minorities among persons receiving Community Mental Health Center Services, including current level of utilization and the level of unmet present and future need. In addition, the Secretary is to conduct demonstration projects as to how to increase minority utilization to appropriate levels.

Mental Health Manpower. The Secretary of Health and Human Services is directed to conduct a study examining (a) the adequacy of manpower for meeting present and future mental health needs of the elderly, and (b) the optimal utilization of the various types of mental health professionals for meeting those present and future elderly mental health needs. Also, the Secretary of Health and Human Services is to conduct a study examining the adequacy of (a) manpower for meeting present and future mental health needs of ethnic and minority group elderly, and (b) opportunities for training ethnic and minority group mental health professionals.

Sec. 2604. Effective date. The above mental health provisions take effect on October 1, 1989 or upon enactment.

Sec. 2611. (MH) Requiring provision of outpatient mental health under Medicaid (Effective 1/1/90-12/31/94). Medicaid programs are required to include community based mental health services for eligible recipients, including those in their homes or in a nursing home, on the same basis as physician services.

Sec. 2612. (MH) Classification of institution for mental diseases under Medicaid. (Effective 1/1/90-12/31/94). The definition of Institution for Mental Disease under Medicaid is clarified as follows. It specifies that a facility may be classified as an Institution for Mental Disease (IMD) under Medicaid only under the following conditions: (1) the facility is under the jurisdiction of the State's mental health authority, (2) the facility advertises itself as primarily specializing in the treatment of individuals with mental disease, or (3) based upon current diagnosis, less than 50 percent of all patients in the facility have a physical condition independently sufficient to require nursing home care. The delivery of mental health services or psychopharmacological drugs to patients with physical conditions independently sufficient to require nursing home care shall not be considered an indication that a facility is an Institution for Mental Disease (IMD) under Medicaid. Further, a facility staffed with specialized psychiatric or psychological trained persons shall not be considered an indication that it is an Institution for Mental Disease (IMD) under Medicaid.

Sec. 2613. (MH) Conditions of participation for nursing facilities under Medicare and Medicaid. Effective with OBRA '87, access to mental health services for all nursing home patients is required as a condition of participation under Medicare and Medicaid.

Sec. 2614. (MH) Additional conditions of participation. (Effective 1/1/91). The Department of Health and Human Services is required to establish conditions of participation as follows:

- All mental health providers under Medicare and Medicaid shall (a) comply with the Consumer Bill of Rights (see Bill of Rights below), (b) provide the client with written grievance procedures appropriate for all services, and (c) give in writing the services to be provided. Note: In this Act, "mental health providers" means a psychiatrist, psychologist, clinical social worker, psychiatric nurse specialist, psychiatric hospital, hospital programs (under section 1905 (i)), and an institution for mental diseases.
- All mental health providers under Medicare and Medicaid shall have (a) the capability to identify clients who may be in need of mental health services, (b) the capability to provide such services or to make appropriate referrals for such services, and (c) the means to coordinate with other agencies, programs, and services providing mental health services or other services to the client.
- All mental health providers under Medicare and Medicaid shall (a) include in their client assessments an assessment of mental health needs at a level sufficient to identify clients for whom a comprehensive mental health assessment, conducted by a mental health professional, is indicated, (b) provide or arrange for such comprehensive mental health assessment when indicated, and (c) when appropriate, include mental health services in plans of care and discharge planning.
- All mental health providers under Medicare and Medicaid shall have (a) client care processes which include a plan of care which states reasonable goals and objectives, services to be provided to meet those objectives, and outcome measures for each client served, (b) a method for periodic review of client needs and the plan of care, and (c) a statement of criteria for discharge and/or transfer to another agency, program, or service.
- All health maintenance organizations or competitive medical plans providing services under Medicare and Medicaid shall provide, according to regulations determined by the Secretary of Health and Human Services, an appropriate package of mental health benefits and an appropriate mechanism for ensuring quality of and access to services provided under those benefits.
- All hospitals and nursing homes providing services to chronically mentally ill individuals under Medicare and Medicaid shall have a discharge plan for all such individuals which assures that they will have a plan for mental health care and for coordination of services established prior to discharge.

Sec. 2615. (MH) Peer review of mental health services. For both Medicare and Medicaid, future contracts (after enactment) for PRO review shall incorporate review of all new and current services provided under those programs as a result of this Act.

Sec. 2616. (MH) Review of levels of payment for mental health services. (Effective 1/1/90). Secretary is required to review adequacy of mental health payments for nursing home residents.

Title VII. Alzheimer's Assistance Development.

Sec. 2701. (ALZ) Grants to states for Alzheimer's Disease programs. A joint federal/state effort is established to develop services and policies to assist victims of AD and their families. All 50 States and territories may receive grants to create State Alzheimer's Programs.

- Develops diagnostic, treatment, care management, legal counseling, and educational services for care providers, victims, and their families. Makes available respite care services (including, but not limited to, home health, day care, companion, short term stay in health facilities), for the AD patient. Between 25% and 50% of the grant is to be used for this purpose. Disseminates information to victims, their families, health care providers, and organizations established for patients with AD, and to the general public on services available to AD victims as well as on rights of and sources of assistance for AD victims and their families.
- Review state policies on the financing and reimbursement of the costs of health care for patients with AD and identifies other policy changes that would improve the care of patients with AD.
- Makes initial grants available for 3 years with funding at a minimum of $250,000 per year and subject to an annual evaluation by the Department of Health and Human Services. States are required to provide matching funds at a 50-50 rate. Total program funding is set at $50 million for 1990, $100 million for 1991, and $125 million for 1992.

Sec. 2711. (ALZ) Assuring adequate funding for treatment of individuals with Alzheimer's Disease. (Effective 12 months after enactment). The Health Care Financing Administration (HCFA) is directed to modify the Medicare and Medicaid programs to review and, as needed, modify reimbursement for home health services, extended care services, and inpatient hospital services to reflect more accurately the cost of caring for advanced stages of AD.

Sec. 2712. (ALZ) Upgrading quality of care reviews for heavy care patients. The Health Care Financing Administration (HCFA) is directed by January 1, 1990 to modify the Medicare and Medicaid programs to upgrade quality of care and utilization reviews for heavy care patients such as AD patients.

Sec. 2713. (ALZ) Assuring access to needed services. The Health Care Financing Administration (HCFA) is directed to propose modifications (within 12 months after enactment) in the Medicare and Medicaid programs to ensure that access to nursing home and home health care for AD victims is not limited by the practices of nursing home and home health agencies.

Title VIII. Community and Migrant Health Centers Expansion. (Sec. 2801) (RUR)

Community health center and migrant health center funding authorization is increased by 10 percent each. Authorized funding for community health centers is $517 million for 1990 and such sums as are necessary for subsequent years. Authorized funding for migrant health centers is $55.5 million for 1990 and such sums as are necessary for subsequent years.

As noted in the text, several provisions in the "USHealth" Program Act are drawn from other legislation introduced by Representative Edward R. Roybal, including the Mental Health and Aging Act (H.R. 111), the National Rural Health Care Act (H.R. 950), the Nursing Shortage and Nurse Reimbursement Incentives Act (H.R. 1140), the Comprehensive Alzheimer's Assistance, Research, Education Act (H.R. 1490) and an expanded version of "Pepper-Roybal" Long Term Home Care Act (H.R. 2263). In the bill description, these provisions are indicated by the following initials: "MH" -- H.R. 111, "RUR" -- H.R. 950, "NRS" -- H.R. 1140, "ALZ" -- H.R. 1490, and "LTC" -- a comprehensive long term care package which includes most of H.R. 2263.

For more information on the "USHealth" Program Act, contact Gary Christopherson, Yvonne Santa Anna, or Julie Utroska at the House Select Committee on Aging (202-226-3375), Room 712, House Annex 1, Washington, D.C. 20515.

Chairman **Rockefeller**. Thank you, Chairman Roybal. We appreciate your courtesy and your long experience and wisdom very, very much.

Congressman Walgren. Unfortunately, sir, you will be under the 5-minute limit.

STATEMENT OF REPRESENTATIVE DOUG WALGREN

Representative **Walgren**. Well, that's fine with me, Mr. Chairman, and I want to express my appreciation for being able to join you and for appearing in your process.

There is no Commission I know of that, in my time in the Congress, has had a greater responsibility than yours and you in responding to the problems of health care. But it's also true that there may be no Commission that has had a greater example and a greater legend to live up to than that which Senator Pepper gave through his service over so many years in the pursuit of broader access to health care in our country.

And I especially appreciate the chance to join Congressman Roybal. Congressman Roybal says that his proposal is one man's view. It is far more than one man's view. It is the result of intense involvement on a broad base with our society over the years and has so much wisdom behind it that I want to commend it to you. And it is with a little bit of an apology that I focus on only part of the problem, because Congressman Roybal's comprehensive approach and something on that order, I think is clearly what will be needed in the long run and even the very short run for our country.

I came across the problem that you, Mr. Chairman, referenced in your opening statement, of preexisting conditions through an involvement with those who struggle with rare disorders and they, as you can imagine, have been broadly confronted with being problems of access to health insurance because their condition is largely or usually genetic and obviously preexisting. And they are unable to secure access to any health insurance because of that.

But in touching on rare disorders, I think we touched a very broad-based problem that is reflected in the private health insurance system today. It is almost a poison pill, in a sense, that is built into the profit motive and all the signals that we ask the private insurance business to operate under, that as they try to reduce the costs on their bottomline to compete in a razor sharp competition to sell group insurance, they have every incentive to exclude from that coverage, by individual conditions or outright personal exclusions, the coverage of the people who need health insurance the most.

And it's a simple insurance problem, in a sense. We've had the same problem with automobile insurance and Government has essentially mandated the solution to that problem through the assigned risk of high risk drivers to risk pools on a State basis. The problem is very similar. Clearly, they were also excluded from access to insurance and that presented a problem that clearly in the society's interest had to be solved and there were ways found to solve it.

I believe we certainly, at least, owe it to those who are left on the outside, through preexisting conditions, to solve that problem for them in a similar way. It is a very broad-based problem. The estimates are that at least 1 in 5 are denied health insurance access for the condition that will cause them the most expense and which we look for health insurance to truly solve and spread the cost of that burden, because it clearly is beyond individuals. And yet, 1 in 5, by most estimates, are excluded from that.

The end result is that only the generally healthy people in the insurance system will be insured and as people change jobs, and we know in our economy these days we are asked to change jobs frequently, people encounter problems. Gone are the days when one would go with one company and have that position for a lifetime of work. Instead, we need to be retrained and there is great volatility in our work force. And every time somebody changes jobs, they then start from the outside and are subject to denial by this kind of exclusion.

There's a strange comparison to agriculture, where to follow the incentives in a very productive society, the farmers will plant hedgerow to hedgerow and as a result drive the system right into self-destruction. In this instance, to meet the competitive importance of price in selling group insurance, the insurance companies will use preexisting conditions to the point that those who need the health insurance are essentially excluded from it.

I have, Mr. Chairman, and I'd like to submit, for your record, a number of letters of the individuals that have come to my attention, because of a bill that I have introduced on the House side, House bill 2649, dealing with preexisting condition exclusions. It seems to be a very manageable problem, one that I would like to submit for your consideration in the process of your deliberations.

But again, I would go back to the point that this is only part of the problem and solving it will not solve the basic problem that your Commission has addressed and that Congressman Roybal and others have called such attention to, the need for comprehensive, all-inclusive access to health care. Thank you, Mr. Chairman.

[The prepared statement of Representative Walgren follows:]

[The letters referred to appear in the Appendix, pp. 419–541.]

TESTIMONY OF CONG. DOUG WALGREN

October 24, 1989

before the U.S. Bipartisan Commission on
Comprehensive Health Care

I greatly appreciate the opportunity to appear before you today and commend you for the attention you are bringing to the problems many Americans have in getting adequate health care.

I want to specifically focus on the area of "pre-existing conditions" and the problems people with pre-existing conditions have in getting private insurance.

I have introduced a bill, H.R. 2649, which would prevent private providers of health insurance from denying health insurance to, or otherwise discriminating against, persons with pre-existing medical conditions. This, of course, is a very controversial proposal in the insurance field, but one that deserves our attention because the result of these practices mean that those who need health insurance the most -- the sick and the disabled -- are often denied insurance protection.

Although there is little specific information on the number of people who are denied health insurance because of pre-existing conditions, there is every reason to believe this is an important problem. The Office of Technology Assessment estimates that 20 percent of those applying for commercial health insurance receive a substandard risk classification that produces an above-average premium or a pre-existing condition exclusion. The National Commission on Orphan Diseases estimated that 16 percent of those with rare diseases were unable to acquire adequate insurance.

These denials take several forms: Individuals may not be able to purchase any health insurance of any kind; they may be able to purchase health insurance coverage for everything except the pre-existing condition; they may be offered coverage at rates much higher than "normal" people; or they may be offered coverage only after a lengthy waiting period.

By excluding or in some way limiting coverage for people with pre-existing conditions, commercial insurers cover only the "healthy," leaving those who are ill without the ability to use insurance to spread their risks or medical costs beyond themselves.

Denying access to insurance because of pre-existing conditions creates several problems. First, leaving people without adequate insurance, quite simply, leaves them sick. Without substantial resources, they cannot get care. And as illness is neglected, it is only exacerbated, making whatever care they eventually get more expensive than it otherwise would have been.

Second, persons with pre-existing conditions often must pay extremely high premiums, costs that are out of reach of most families. A family in Tennessee saw the cost of their health insurance grow from $170 per month to $600 per month after the birth of a daughter with a severe genetic defect.

Third, people with pre-existing conditions may be denied employment. It is commonly asserted that individuals who become seriously ill are often not willingly brought back to work by their employer because a company health plan would be adversely affected. In other instances, insurers have pressured employers to drop persons from a benefits plan because the employee or a member of the employee's family has a serious illness.

Fourth, oftentimes individuals who have full insurance through their work are trapped in one job because they may be unable to get similar coverage if they change jobs.

Fifth, denying insurance to people means they end up in hospital emergency rooms, where we all pay for their care through higher premiums or government programs after they prejudice their health by failing to get care when they first need it, and only after they impoverish themselves, their families, and the hospitals we all must turn to. That's no way to organize health care.

Finally, many people with a pre-existing condition -- something as common as high blood pressure -- are afraid to use what coverage they have for fear that the condition will be discovered and used to deny their coverage. The fear of being denied health insurance because of the jeopardy to one's insurability is a disincentive to getting health care, which only exacerbates the illness. Health insurance, public or private, should be designed to help people prevent illness and cure illness, not contribute to continued illness.

HISTORY

It is helpful to look back on the evolution of health insurance in this country. In early 1930s, the Depression years, Blue Cross/Blue Shield programs were developed by hospitals and doctors who wanted to "guarantee" a form of payment for their services. These early plans offered "service benefits," paying in full for covered services. They used "community rating," under which premium amounts were based on expected costs for all policyholders; the cost burdens were shared over a broad base. And third, most of the Blues had a policy of "open enrollment," permitting any individual or group to purchase coverage.

Over the years, the nature of private coverage changed as the insurance industry grew. Instead of paying in full, plans offered "indemnity" coverage, paying a fixed amount for each service and leaving the enrollee to pay the balance. Commercial insurers began to use "experience rating," under which the rate for each employer group was based on historic costs for that specific group. And commercial insurers began to use underwriting practices similar to those traditionally used in other lines of insurance, such as life insurance. Insurers began to charge high-risk applicants higher rates or deny coverage for serious or chronic health problems.

According to a Congressional Research Service study, "The differences between the practices of the Blues and commerical insurers have diminished over time. 'Indemnity coverage is increasingly rare, especially in employment-based plans. Most of the Blues now use experience rating for large employer groups and many -- though not all -- have modified their enrollment policies, using underwriting to limit their risks." According to the World Institute on Disability in a recent study, "Medical underwriting for individual and small group coverage is becoming more restrictive as competition increases among insurers under the pressure of cost containment."

EXAMPLES

Since the introduction of my bill, many individuals have written me to share their difficulties in getting health insurance. I would like to submit some of these letters to you and will summarize several of them.

A woman from Pittsburgh wrote that her insurance company terminated her policy because she has multiple sclerosis.

One mother wrote that her daughter, Becky, was born with a birth defect which "left her with only 10% of her small intestine. Becky requires daily intravenous feedings which have caused liver disease. When Becky was born, the family's premiums were $200 per month with a $500 deductible. In July 1989, the premiums jumped to $800 per month.

Another woman wrote that after her husband's kidney transplant their insurance went to $5,000 per month.

A Tennessee woman underwent bone marrow transplant surgery for leukemia, believing she had a good insurance policy. She believes that her employer refused to allow her to return to work because her experience would increase the group health insurance rates. Under the terms of the group policy, if she does not return to work in the current calendar year, she will be treated as a new hire and her pre-existing condition will be excluded from coverage. This, then, would not affect the employer's experience rating or premiums. But it effectively terminates her coverage and her ability to use the insurance system to spread the burden.

The daughter of one of my constituents, who has a rare disease, moved to Canada and lives with relatives because she is not insurable in this country.

An Oregon family wrote that their insurance coverage was "approved" for the parents and two children, but denied for their third son, Michael, because of "mild cerebral palsy" -- this despite the fact that this is only a mild condition. According to his physicians, "This child is in school, his general health has been good, he has had not hospitalizations, and no one anticpates that his condition to create significant long-term medical complications."

An Oklahoma man with acute intermittent porphyria, a heriditary enzyme deficiency, wrote that he has been totally denied health and life insurance for ten years. He wrote, "The conclusions by underwriters at insurance companies when confronted with genetic problems leads one to believe they do not intend to make an effort to understand. It is much simpler to categorize and deny health or life insurance to the applicant. This is not just a problem of genetic discrimination. All insurance companies insure the healthy. They do not insure persons with questionable health."

. . . . .

It seems to me that access to health care is so important, and the cost so clearly beyond each of us alone, that everyone should at least have access to health insurance. And, if insurance is to be meaningful, every individual should be able to join a large enough group that they are put on an equal footing with regard to cost that any other insured person enjoys.

In short, all must have access to insurance spread across a large number of policy holders which represent a fair cross-section of the health needs of the public at large. Although we may not be able to provide universal health care in our country at this time, we ought to provide universal access to health insurance in the private sector regardless of the risk present because of medical circumstances beyond our control.

Our ethics should dictate that, as long as we are going to depend on private health insurance in this country, government has an obligation to insure that people at risk are able to participate in the insurancesystem. Discriminating against people based on their health condition violates the premise of insurance that we should all share the risk and spread the cost broadly.

H.R. 2649

The Federal Health Insurance Equity Act of 1989 has three prohibitions: (1) It would prohibit insurers from excluding, terminating, or otherwise limiting any individual from coverage based on a pre-existing condition; (2) It would prohibit the sponsor of a health benefit plan from determining coverage rates for an individual or group on the basis of claims, a practice known as experience rating; (3) It would establish benefit standards for the provision of basic health benefit plan services at a reasonable cost.

The bill would require the states to enact benefit that are standards comparable to minimum federal standards established by the Secretary of Health and Human Services. States and plans would be given forty-two months to comply. Health benefit plans found out of compliance would be subject to civil penalties. The bill would also require the establishment of state offices to investigate allegations of abuse.

Opponents of this bill say that forcing industry to assume coverage of persons known to require significant amounts of care will increase premiums or expose insurance companies to unanticipated costs of those who would only seek insurance when they are sick. The bill seeks to address this by requiring the Secretary to determine the fair costs for coverage for those with pre-existing conditions and by recognizing waiting periods and minimum enrollment periods to prevent subscribers from "hopping in and out" of plans or buying coverage only when illness strikes. Waiting periods and minimum enrollment periods would, however, have to be uniformly applied to all applicants and could not discriminate against persons with pre-existing conditions.

Others say that high-risk individuals should be insured by state-run risk pools with the excess costs covered by general revenues. Perhaps so, but those who would argue that government should fill this gap certainly should be supportive of any proposal that would fill this need as long as there is a fair distribution among a broad enough base.

Addressing pre-existing conditions does not represent the total solution to the problem of inadequate access to health care in this country. We are all struggling with the difficulty of developing a truly comprehensive health care system. We know that a public program will be expensive: Long-term care for the elderly alone will cost $50 billion. And we have traditionally had a pluralistic health care system.

Illness and disability can strike any of us at any time. Our public health is vital to , our productivity, our children's future, and ultimately our national strength. The United States remains the only industrialized nation without a system of comprehensive health insurance. By bringing in those now excluded by pre-existing conditions, this bill could provide coverage for a significant unprotected segment of our society.

Chairman ROCKEFELLER. Thank you very much, Doug. And of course, you may say it's a small part of the problem, but it's a very major part of the problem that you address yourself to and we thank you very much.

Barbara Matula, you're quite right; you have been elevated into panel No. 1.

Ms. MATULA. Thank you.

Chairman ROCKEFELLER. And you're speaking on behalf of the American Public Welfare Association as you are the State Medicaid director for the State of North Carolina and we welcome your testimony.

STATEMENT OF BARBARA MATULA, STATE MEDICAID DIRECTOR FOR NORTH CAROLINA, ON BEHALF OF AMERICAN PUBLIC WELFARE ASSOCIATION

Ms. MATULA. Thank you very much. For those of you who don't know, APWA, the American Public Welfare Association, is a 50-year-old nonprofit organization, which represents the 50 States human service agencies, and over 800 local agencies, as well as individual members. We're charged with the public welfare and income assistance in Medicaid Programs in most States.

Medicaid, as you know, is supposed to be the Nation's program to serve health needs of the poorest individuals and families. It's also the largest public financing vehicle for long-term care services. And as administrators, we're well aware of the program's strengths and weaknesses, some of its limitations and its liabilities.

Because of this, almost 3 years ago APWA initiated a study, a very comprehensive study, beginning with Medicaid, but it included all access issues and ultimately long-term care financing and service delivery issues. We believe that both issues, as we've heard this morning already, universal access to health care and long-term care financing reform must be addressed concurrently, as you're attempting to do in this Commission.

I'm going to very briefly summarize our findings. I know our time is short. We all know that poverty and poor health go hand in hand, but we also know that the problem of access to health care goes beyond the poor to millions of workers and their families who have no health insurance. As a result of no health insurance, they have little or random access to health care.

Our recommendations for access to health care are built on two principals. One is that individuals do have a responsibility to obtain health care coverage for themselves and their children when it's available and affordable, and second, society has an obligation to ensure access to health care for all of its citizens. We recommend reform of our health care financing system through a public-private approach for universal coverage.

Our first recommendation is that for workers and their families, employer-sponsored health insurance plans be made available to cover basic health benefits. This would include hospital, physician, prenatal, well baby, and well child care, diagnostic and screening tests. We felt that ancillary services such as prescription drug and dental might be added later, but to begin with we would propose this minimum basic health benefit package for all employers to offer. To hold down costs, we support case-managed care, insofar as it can direct care that is appropriate and necessary.

This basic benefit, we feel, should extend to part-time as well as full-time employees and their families and we would have employees share at least 20 percent of the cost of premiums. Recognizing, as we do, the resistance of small business to such an employer mandate, we support development of a system of regional insurance pools to help spread the costs and make the small employer's costs more affordable. We also believe that States could further assist small business through some subsidy mechanisms, perhaps economic development funds.

Our second recommendation is, that Medicaid be restructured to cover all the nonworking population, including those individuals and their dependents. Eligibility under Medicaid, then, would be broadened and vastly simplified over what it is now and services would again be comparable to the basic health package that we are recommending employers to offer. Uninsured workers who participate in Medicaid would pay an income-related premium if their income was higher than the poverty level.

Our proposal tries to build on existing programs and structures and it really offers both public and private investment, not only in the future health and well-being of our citizens, but also that of our economy.

Our second task force on long-term care, on the other hand, had very difficult issues to deal with. We haven't released our final report yet, but I can give you some of our thinking and then the basis of our recommendations.

We know that the cry for reform becomes more acute each year. We are all still smarting from the public confusion and frustration over the Medicare catastrophic coverage legislation. We think, though, that this has really served to heighten our awareness of the gaps in coverage that all of us want to see closed at an affordable price. The number of frail and disabled Americans in need of assistance from others is growing at a very rapid rate, as you know, and little funding is available to provide the necessary social supports in the community. The vast majority of support or assistance is provided by family and friends.

Of the $50 billion spent on long-term care last year, $38 billion was spent for institutional care and Medicaid was the largest public payer, about $18 billion. The rest was basically out-of-pocket. What's wrong with Medicaid being such a major payor of long-term care? Many things: it's means-tested; it's available only to the poor; its categorical structure means that a nonelderly person has to meet stricter criteria for disability than the elderly; it's a medical model, and we are saying that disability and frailty are not diseases and they don't need cures in the same sense as the medical model provides.

We think there's a great opportunity for reform here to develop a social model of service delivery that's client centered in the home and in the community. To summarize very quickly, with the yellow light on, I would say that we could base a long-term care system on the waiver model that States have so successfully shown to be a deterrent to institutional care. We would recommend that institutional care be the service package of last resort and we have an interesting financing proposal, but the red light's on, so I'll stop there.

Chairman **Rockefeller**. We have the proposal in the record, Barbara.

Ms. **Matula**. Yes, you do.

[The prepared statement of Ms. Matula and proposal referred to follow:]

APWA

AMERICAN PUBLIC WELFARE ASSOCIATION

Ruth Massinga, President
A. Sidney Johnson III, Executive Director

TESTIMONY OF

BARBARA MATULA

DIRECTOR
DIVISION OF MEDICAL ASSISTANCE
NORTH CAROLINA

Representing the
AMERICAN PUBLIC WELFARE ASSOCIATION

Before the
PEPPER COMMISSION

U.S. BIPARTISAN COMMISSION ON
COMPREHENSIVE HEALTH CARE

Hearing on Options in Access to Health Care

October 24, 1989

APWA

AMERICAN PUBLIC WELFARE ASSOCIATION

Ruth Massinga, President
A. Sidney Johnson III, Executive Director

Mr. Chairman, members of the Commission, I am Barbara Matula, Medicaid Director of North Carolina. I am here today as Chairwoman of both the American Public Welfare Association (APWA) Access to Health Care Task Force and the APWA Long Term Care Reform Task Force.

The APWA is a 59 year old non-profit, bipartisan organization representing the 50 state human service departments, 800 local public welfare agencies and 5,000 individuals nationwide. APWA believes that health care is critical to strong, stable, and self-sufficient families. We also believe that national policy must reflect a commitment to meeting acute and long term care needs.

I would like to thank you for the opportunity to testify today and to commend this Commission for its efforts to address the need for improved access to health care and long term care reform.

We are all well aware of the shortcomings in the current health care delivery system in this country. The recent debate over the

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Catastrophic legislation has heightened our awareness of the gaps in coverage that all of us want to see closed. Though we are still smarting from the public confusion and frustration over Catastrophic, there can be no question about the commitment of Congress and the States to continue to search for ways to create equal access to health care and equitable financing for long term care for all Americans.

Human service administrators are charged with a special responsibility to the nation's poor. In addition to administering social services and income assistance, we administer health care programs, through Medicaid and other state-only programs, for poor individuals and families. While Medicaid provides coverage to certain of the poorest families, many more Americans have neither insurance through their workplace nor access to the protection offered by Medicaid. The working poor and those striving to be independent of the welfare system need policies and programs that assure their access to health care.

The Medicaid program, which states administer together with the federal government, finances both primary and acute care for the very poor. Medicaid is also the major financing program for long term care services in this country. State human service administrators are well aware of the Medicaid program strengths, as well as its current limitations and liabilities.

Because of our experience in operating the Medicaid program, our knowledge of how it works, and our responsibility to varied constituencies that rely on the program, we initiated a comprehensive study ofMedicaid, access issues, and long term care financing and service delivery issues.

APWA has looked at both the issue of universal access and the issue of long term care financing reform from the state agency perspective. We believe that both of these critical issues must be addressed, if not concurrently, then in relation to each other, as the Commission is attempting to do. This relationship is critical from a financing/budget perspective. APWA published its report on universal access in the fall of 1988. Our long term care recommendations were adopted in June of this year and a report will be forthcoming shortly.

Let me first address the issue of access to health care and our recommendations.

ACCESS

The statistics on access to health care are before us. One out of every six American children has no health insurance, public or private. One child in four is born into poverty. Among poor children, one in three lacks health care coverage. Access to health care for the poor--poor children in particular--has deteriorated in the last few years. Today in our country poverty and poor health go hand in hand.

While poverty and poor health frequently occur together, the problem of access is an even broader phenomenon. Lack of access is often a result of medical indigence among those not properly defined as "poor." Well over 30 million Americans, the majority of whom have ties to the workforce, lack health insurance and regular access to health care.

To address this profound gap in our national health care service delivery, APWA has developed several recommendations, built on the following two principles: 1) individuals have a responsibility to obtain health care coverage for themselves and their children when it is available and affordable; and 2) society has an obligation to ensure access to health care for all citizens.

The APWA policy report, Access, calls for reform of the health care financing system through a public/private approach to universal coverage. For workers and their families, APWA recommends employer-sponsored health insurance to cover, at a minimum, hospital and physician services; prenatal, well-baby, and well-child care; and diagnostic and screening tests. APWA recommends phasing in, at a later date, coverage of prescription drugs, dental services for children, and eye care. APWA believes that there are ways to structure the program to include both part-time and full time workers and their families. We also believe that some of the well-publicized objections of small employers could be met by developing a system of regional insurance pools that could create large risk pools and provide coverage at rates similar to those for large firms.

The APWA proposal also calls for government assistance for those workers who cannot afford their portion of the insurance costs (20% of premium costs for full-time work). This assistance would be based on the level of income as a percentage of poverty. The proposal calls for employers to pay the health costs of part-time employees in proportion to the number of hours worked (with 80% being the top payment on behalf of full time workers). In addition we believe states could assist small business, for whom the provision of health insurance might prove to be an untenable proposition, through some subsidy mechanism, perhaps through economic development funds.

The APWA proposal specifically calls for coverage of part-time and full-time workers so that there is no incentive to reduce employees from full-time to part-time employment to evade the coverage mandate. We believe that sectors with a poor track record of coverage are those who would be most able to restructure their workforce to evade the intent of the mandate if only full-time workers were covered.

For non-working individuals and their families, APWA recommends restructuring Medicaid to cover all non-working individuals and their dependents. Eligibility would be broadened and simplified. The unemployed and their dependents would be eligible for a basic package of services that would be comparable to the minimum package required in the workplace. Families and individuals with incomes between 75% and 200% of poverty would be required to pay an income-related premium, while those above 200% would pay the full amount of the premium.

The APWA proposal for increased access to health care, like the following proposal for long term care financing, builds upon existing programs and structures. It is a comprehensive approach that would provide access to all those currently in need.

We believe it is time to develop a truly public/private approach to health care coverage. The government cannot shoulder the responsbility for care of the uninsured, especially as the growing number of uninsured skew the costs of medical coverage and medical care throughout the health care system. The federal and state governments, together with the private sector, must broaden coverage. These recommendations reflect what we believe is a critical investment in the future health and well-being of our citizens, the economy, and the country.

Long Term Care Reform

The need for long term care financing and service delivery reform becomes more clear and more acute each year. Our keen awareness of the absence of an affordable continuum of services has grown right alongside the growth in the elderly population, though the needs are not limited to the aged. The elderly number some 30 million today and this number is expected to grow to 55 million by the year 2030, when one out of five Americans will be 65 years of age or older.

Nearly a quarter of the elderly population, 6.3 to 6.5 million persons, require the assistance of others in the performance of Activities of Daily Living, or ADLs. Roughly 40% of the total disabled population, however, is made up of non-aged individuals. Cognitive impairments and disorders as well as diseases such as AIDs and Alzheimer's are affecting younger populations in increasing numbers and are exacerbating the need for extended care services.

Because there is little funding available to provide necessary social services to the disabled elderly and non-elderly in the community, the vast majority of care is provided informally, by family and friends, the majority of whom are women. Half of these caregivers are employed outside of the home and most work full-time. The trend toward delayed childbearing, coupled with decreased fertility and the increased life expectancy of the aged, all effect the amount and quality of informal care that can be provided. Set against the rising needs of an increasingly elderly population, today's families are simply not able to completely fulfill the need.

Total long term care expenditures in the United States, from all sources, approach $50 billion a year. Institutional care alone accounts for $38 billion. Over half of this $38 billion is paid by individuals, out-of-pocket, and the remainder is funded generally through public funds.

The major financier of long term care services in addition to the individual is Medicaid. APWA believes that providing this service is an increasingly inappropriate role for the Medicaid program. It is a means tested program, generally requiring impoverishment before financial assistance is provided. Additionally, it is a medical model program, originally designed to finance the primary health care needs of the very poor. Medicaid, because of its medical model foundation, contains a funding bias toward institutional, medical care, often to the exclusion of community-based services. It is a model predicated on the concepts of disease and cure. Disability and frailty are not properly catagorized as disease, and there is no "cure" ready at hand.

Even though Medicaid laws now permit provision of home and community based social services to the elderly through a special waiver program, the number served is well under one percent of the elderly population. In addition, only a small percentage of the elderly in the community receive any formal home health or visiting nurse care (2% and 3% respectively).

Medicare, like Medicaid, is a medical model program, funding the acute and sub-acute care needs of the elderly and disabled. It does not finance a broad array of non-medically oriented care. Medicare law requires that a disabled individual wait at least two years before becoming eligible for Medicare coverage. Because of its own medical model bias, Medicare accounts for only about 2% of all institutional care, and roughly 10% of all in-home health service expenditures (while Medicaid pays for roughly one-third of all in-home services).

Opinion polls today show that the public believes the financing of long term care is a significant issue that must be addressed. A key finding of some of these polls is that long term care financing should be available universally and not restricted to either the poor or the elderly.

State agencies have a primary responsibility for the financing and administration of long term care services for a variety of populations. We bring that collective experience into our proposal on long term care reform.

APWA has come to believe that there is a role for both the public and private sector in developing a service/financing model to provide a full continuum of social and health services to the disabled and frail elderly.

In looking at public and private sector approaches to long term care financing, APWA evaluated current programs for their future feasibility. Each approach was evaluated against several criteria, all crucial to the success of a long term care program. We believe that a long term care program should be equitable in its coverage; affordable for the beneficiaries, government and the private sector, flexible in its approach and administration in order to promote access to a range of social and health services, uniform in providing for the development of a minimum level of a variety of services available across the country; and it must be of consistent quality in order to provide a minimum level of care to be met by all providers.

A social insurance model best meets this criteria and is the basis for the long term care proposal APWA recommends. By stressing the social model of service delivery and client directed care, the program would focus on the provision of home and community based social services designed to maintain the individual's maximum independence in the community. Insitutional care would be the service package of last resort, so to speak, available when medical need or physical impairment is so great that home care is not practical.

In the proposed program, individuals would become eligible for services based on an ADL functional assessment. Functional impairment, not the individual's age or type of disability, would determine eligibility.

The community service package would be based on an assessment of the individual's need for assistance and would be limited by an expenditure cap related to the individual's level of impairment. The client's case manager, together with the client and family, would determine the array of needed services within the predetermined expenditure cap.

Supplementing existing informal care is a key aspect of this proposal and, therefore, the case manager would also assess the extent of existing informal support in order to promote a service package that would assist the ongoing support system.

While the client would receive first dollar coverage for home and community based care, a copayment equal to 20% of cost or 10% of income, whichever is less would be required.

Institutional coverage would be provided, with a client co-payment, after a six month waiting period, during which time the client would be expected to use private insurance or personal resources. We believe that by limiting an underwriter's risk to a specific period of time, together with other incentives, policies can be developed that would be affordable. We would also recommend a client copayment roughly equal to room and board in the facility.

The financing mechanisms for the program should be consistent with the goals of a social insurance model. APWA recommends both an expanded payroll tax and an expanded estate/gift tax as appropriate, direct financing mechanisms.

The first part of this proposal would lift the current payroll tax cap of $48,000 for both the Hospital Insurance and the Old Age, Survivors, and Disability Insurance (OASDI). We believe the payroll tax is an appropriate mechanism because both the employer and employee contribute. The current cap is not appropriate for long term care coverage because it does not reflect the fact that wealthier individuals and families gain more by such long term care protection through better protection of their preexisting income and resources. We also believe that since society should eventually view the need for long term care as a universal risk at any age (due to advances in medical technology), everyone should pay into the program.

The second part would reduce the current $600,000 estate tax exemption level to $100,000 and impose a straight 20% tax on all estate/gift transfers between $100,000 and $600,000. We also recommend that provisions be established to protect the low-income individuals who might inherit non-liquid assets. Because the overall proposal would effectively protect an individual's resources during his/her lifetime, it is appropriate to more fully tax those resources as they become an inheritance after the individual's death. A more thorough tax structure in this area would better reflect the benefits to the midddle-income group.

While the overall tax rate should remain the same, the rate structure should be changed so that each person, regardless of income level, pays into all programs proportionately.

APWA believes that a dedicated federal long term care tax is politically possible if: 1) the tax is distributed equally 2) the tax finances needed services; and 3) the majority of taxpayers understand the direct benefit of the services for themselves, their family, and their friends.

APWA believes that this proposal is sound public policy for a variety of reasons. The social insurance model can be designed to facilitate the role of the private sector in both long term care service delivery and coverage. A universal program, with some level of assured funding and coverage, would help assure development of needed services in response to an increased market potential, thereby facilitating a minimum level of service availability across the country. Further, private sector financing can be encouraged through a program designed to limit an underwriter's risk.

A universal social insurance program would require that individuals pay into the program throughout their working lives; thus, because everyone pays in, everyone is potentially eligible for services when the need arises.

Affordability for the individual can be guaranteed by the design of the program. Affordability for government on the other hand, must be viewed within the overall context of a society that presently spends some $50 billion per year on services. Through all of its programs, government pays the lion's share of these costs and pays them in an uncoordinated, irrational manner. If the long term care financing and service delivery system were rationalized, as we propose, the government could serve more people, in more appropriate settings, for the same dollar amount. State experience under the waivers has shown this to be true.

The proposed model would permit building upon already existing state administrative and service delivery systems. The program could provide for a national minimum level of services across a continuum. Quality of care could be assured by the development of minimum national criteria and the utilization of current state systems, and activities for both institutional and home care services.

Looking into the future, it seems increasingly clear that individuals will not be able to finance their care under current options. It also seems clear that general revenue funding, through the Medicaid program, will become increasingly untenable as the disparate demands on the program increase at the same time as program expenditures related to long term care also increase.

Conclusion

APWA believes that the problems with the current health care system can no longer be ignored and that we are headed into a crisis in both areas under review by this Commission.

Congress, the states, and the public must begin to evaluate proposals for change, with serious attention given to concepts that encompass broad and substantive reform. We believe there is a true, practical limit to the incremental expansion of Medicaid as we know it. While we make the program more and more complex to understand and administer, the returns have become marginal in terms of health status, satisfaction, and access to needed care.

APWA hopes that Congress and the states will begin to view each other as true partners in the development of any new strategy, since each level of government has a considerable amount at stake in reform of the current system.

Thank you very much.

Chairman ROCKEFELLER. And we're very grateful to you. Are there questions of the panel?

Commissioner BALOG. Congressman Roybal, I have a question. I was intrigued by your proposing to write right into the legislation a cap as a percentage of GNP for both medical care and for long-term care. And I was curious about what happens under the circumstance that medical costs grow faster than GNP, as they have been for years, and are likely to continue to grow faster—maybe 3, 4, 5 times as fast as GNP. And that's in good economic times. In bad economic times, obviously, GNP goes south and medical care costs go north. What happens when you reach this conflict?

Representative ROYBAL. Well, first of all, under the proposed system there will be a cost-containment mechanism. No plan will work if cost containment is not an important part of that plan. We believe that costs at the present time are excessive. That if we are able to get all of the various components of cost together and the components that make up the delivery system, get them all together and actually coordinate them, that costs would be reduced. Then we'll be able to use more effectively the funds that are generated for that specific purpose.

Now, many do contend that the gross national product will not increase, perhaps, as fast as the cost of medical care. On the other hand, there is an alternative that has to be considered. Under the present plan, if we continue as we are now, we will reach by the year 2000 a system that will spend 15, or more percent of the gross national product. Under the system outlined under USHealth, it will remain at 12 percent. With the cost containment that is involved, it will be able to survive it and it will be able to deliver the care and keep that at a level of increase that is based on the gross national product.

Chairman ROCKEFELLER. Excuse me, go ahead.

Commissioner BALOG. Yes; I think it's very interesting and useful that you put the cost-containment feature right up front and the limitation on GNP. The British system and the Canadian system also ration health care based upon percentage of GNP in their whole political process. They don't have a stipulated number. So, I was intrigued to see that you specified a number and approach it from that point of view, because ultimately you ration resources by one system or another. So, I was intrigued by your idea.

Representative ROYBAL. Thank you.

Chairman ROCKEFELLER. Senator Baucus.

Senator BAUCUS. Mr. Chairman, while we have two Members of Congress here, I'd like their opinion, in view of the catastrophic health insurance debacle, as to how you think we could finance additional coverage, both uncompensated care and long-term health care. What are the most realistic ways, in your view, in the next year or two, to finance those two areas?

Representative ROYBAL. Well, first of all, I think that if one looks on a chart on present costs and that envisioned under USHealth, as an example, that they parallel one another pretty much. But it rearranges the mechanism. Those who are paying into Medicare today stop at approximately $48,000 to $50,000 of income. If you lift that cap then, those of us who earn more than $50,000 will, of course, have to pay our proportionate share.

Everyone would be included under this particular mechanism. There are individuals today, for an example, as the Chairman pointed out in his opening statement, that are working, but do not pay into the system. These are people that when the time comes and need medical attention, and they do get it, and they add to the cost, but not to the income. So, I think that one of the things that can be done is, of course, to lift the Medicare wage cap.

And the other is, I think, outlined already in the statement that I had previously made. That is that we must be able to expand the cigarette tax. That's only one idea. There could be other things.

A premium, then, must continue for elderly Medicare beneficiaries that would approximate the present premiums that the senior citizen community pays at the present time. An employer tax can also be imposed, which is similar to what we have now, and which is based on compensation.

Now, State revenues covering one-half of the cost of the poor can also be part of this, which is similar to what is being done today under Medicaid. In California we call it MediCal. But nevertheless, these costs are involved and, under the USHealth system, we'll be able to take advantage of that by using one-half of the cost of the poor, currently financed by the States.

One thing that is perhaps new, but not really new, just a change, and that is that there be a surtax on corporate and individual income. Now, this would be sufficient for the solvency of the national health plan as a whole. In effect, that is happening at the present time. While we do not specifically call it that, it is something that the private sector is already involved in helping finance.

So, what we do, then, is rearrange all of these things, put more efficiency into the process, and let efficiency, then, take part of the responsibility for reducing costs, resulting in a system that is more efficient than today.

Senator BAUCUS. Congressman Walgren.

Representative WALGREN. My belief is that the catastrophic event which we had with health care in the Congress of the United States, was nothing more than a tax revolt, when there are good arguments that could be made that a very significant increase in burden was placed on a very small portion of the American public. And there is no evidence that I have seen from my constituents that the American people are unwilling, in any way, to make a solid contribution, an increased contribution, to solving pressing national problems that are ethically compelling. And health care is at bottom an ethical question for all of us when we see those who go without it.

I have been struck by some of the comparisons with the German system, where they have been able to design an absolutely comprehensive health care system, which involves something in the range of less than 20 percent public funding, the balance coming from employer-related obligations. We in our country, I understand it, are paying something over 40 percent of our health care bill out of public funds. So, there are really very good ways and lots of mixes that can be developed, if we make as our goal at the outset this comprehensive coverage. I think we can find ways to pay for it that the American people would be very willing.

Senator **Baucus**. Thank you. I don't want to take more of the Commission's time here, but I just think that we have to address this question if we're going to realistically find some solutions. Otherwise, we're doing it somewhat of a disservice. We have to also ask at the threshold the question of how much public and how much private financing you somewhat alluded to, Congressman. I think you're right. I think it was a taxpayers revolt, the catastrophic response here in the Congress and we're going to have to think through much more carefully this time around, compared to what we did last time around. And that's why I asked the question. Thank you, Mr. Chairman.

Chairman **Rockefeller**. Yes; let me just interject something to that before Congressman Gradison has a question. This idea that it was a taxpayers revolt, I'm not entirely convinced by that. I think it was a revolt on the part of a few taxpayers. I mean, I wonder why it was, if the House was so willing to completely dismantle catastrophic health care and there were 73 votes in the Senate against that, is there such a difference in the two bodies? Was it, in fact, a taxpayers revolt?

Recent information seems to show that most people, most seniors, had absolutely no idea of what was involved with catastrophic health care. I'm not at all sure that it wasn't just a fairly well orchestrated campaign on the part of a couple of organizations to excite a few into the appearance of a taxpayers revolt.

And I think this Commission should pay some deference to the phenomena of the catastrophic health experience. I'm not sure that it leads us to any final instructions and even if it does, it may point to obstacles which have to be overcome, habits which have to be overcome. I just continue to be uncertain as to the depth of feeling in regard to catastrophic health care. I saw, even after the Senate finished its business, groups down in the subways virtually attacking Senator Bentsen and Senator Bradley. Certainly tactically not a very wise move. And I'm just not sure how many people they represented.

Congressman Gradison.

Representative **Gradison**. Thank you, Mr. Chairman. I just have to observe that I'm not sure whether it was a taxpayers revolt, but it sure was a congressional revolt that we ran into on our side of the Capitol.

Ms. Matula, first of all, I want to thank you for your assistance to our committee when we were working on the catastrophic health insurance legislation. I thought we did a pretty good job, but I seem to be, if not a committee of one, a member of a very small committee that believes that. But I do believe that.

I wonder if you could outline briefly for us the financing plan which you weren't able to get to in your earlier statement?

Ms. **Matula**. In the long-term care area, which I think is the most important, we too have a cap, but it's a different kind of cap. It would be a cost cap on the services that would be provided in the home and in the community, similar to the one we have in our nursing home waiver plan.

We know the cost of nursing home care and we know that without support at home many people will end up in nursing homes prematurely and for long periods. But by assessing a person's needs for assistance in daily living activities and the severity of their functioning disabilities, we can set a cap against the nursing home costs, invite participation in cost-sharing by the individual, perhaps 20 percent of those costs, and make the rest a social benefit package.

For nursing home care, we would not cover the first 6 months. That would have to be covered out of private resources or insurance. That would mean that this plan would truly be the last resort. And then, if nursing home care were required, again, the individual's responsibility would be great, perhaps equal to the cost of room and board. Now, that's the individual's payment for this because they're not shouldering a large burden.

The public program that would be the underpinnings of the plan, the social insurance, we feel would best be supported by two dedicated tax sources. One being the expansion of the payroll tax, because this is a program that would not be just for the elderly, it would benefit workers today and their children if they, sadly, needed long-term care. So, it's available to everyone regardless of age or income.

But the more important part, I think psychologically, of our revenue proposal, is an estate and gift tax. It is long-term care and institutional care that depletes the elderly or the disabled person's estate that they would like to leave to their children. Our letters are always based on this. They don't mind contributing their pensions and their income and social security, but they hate losing that estate. We protected part of it in spousal impoverishment, but only for married couples. The others still must exhaust theirs.

So, rather than devastate that holding, we would recommend that the tax on estates be increased. For example, now the first $600,000 is excluded. We would exclude up to only $100,000 from taxes. And impose a gift tax also, so that the estate couldn't be distributed prior to the need for long-term care. I think that if Americans see that a tax is a dedicated tax, that it's uniformly assessed, and that they will see the folks receive the benefit, regardless of income as well, they are less resistant to it.

Representative **Gradison**. One other thing. You had mentioned in your testimony the importance of assuring that every American has access to health insurance, if I recall your phrase, and then later you wrote about universal health insurance. And I want to make sure—this is a discussion we're having within the Commission. Which way do you want it to go? I mean, if it's universal, I assume that means everybody has to have it. If it's access, that means everybody has to have it available, but some may choose not to take advantage of it. They may not want to pay the 20 percent. Well, what are you talking about? Is it mandatory or isn't it mandatory?

Ms. **Matula**. It has to be mandatory. Universal because we're talking about two populations, employed persons and unemployed persons. So, the universality means that we are making all health care insurance available— when I say available, I'll qualify that in a minute—to both employed and unemployed. The vehicle is the mandated employer benefit.

Folks who are employed and who do not voluntarily accept the insurance or pay on behalf of their dependents will continue to exacerbate the problem we have now of uncompensated care, because there will be an accident, a trauma, an injury, and they can't pay the hospital bill. The bill then is tacked on to those who have already paid through employer benefits.

Representative **Gradison**. Then, if it's a 20-percent payment, it isn't just mandatory employer payment, it's mandatory——

Ms. **Matula**. It's mandatory——

Representative **Gradison** [continuing]. Employee payment as well, right?

Ms. **Matula**. We say in our principals that it is the responsibility of the individual to take responsibility for himself and his dependents. We are mandated to have car insurance and fire insurance. I think we can be mandated to take health insurance.

Representative **Gradison**. Thank you. Thank you, Mr. Chairman.

Chairman **Rockefeller**. Congressman Stokes.

Representative **Stokes**. Thank you, Mr. Chairman. I'd like to follow up on the question really posed by Chairman Rockefeller and I'd like to ask Chairman Roybal to respond. Your package is, as you say, totally self-financed through a funding package reflecting much of what we pay for care now. But basically it is based upon additional taxes. For instance, a cigarette tax; you have a Medicare payroll tax; employers tax based on compensation; State revenues; surcharge on corporate and individual income taxes.

I think we have to meet this whole financing question head on, right out front. And I'm just concerned, in light of the action that was recently taken by the House in terms of the repeal of the catastrophic illness insurance legislation, the action taken in terms of cutting the capital gains tax, the President's posture in terms of “read my lips, no new taxes.” Is this the realistic approach toward this type of financing?

Representative **Roybal**. Well, first of all, Mr. Stokes, the USHealth is not based on new taxes. The only new tax that is really recommended is the cigarette excise tax. All the rest of the taxes and all the moneys that come in are actually a rearrangement of the present plan. There are no brand new additional taxes, but a rearrangement. Now, if the cigarette tax is included, yes, that would be an addition.

Now, the difference between catastrophic and a national health plan is very simple. Catastrophic placed the burden of payment on seniors, on the elderly. That is why we had a so-called revolt of the elderly. This wasn't a revolt of the general taxpayer in the country, but the elderly. A USHealth plan would place the burden on all segments of the population, on all individuals, on all Americans.

Again, in answer to your question. I don't think that this is a brand new tax system that we're devising, but we're rearranging the present system and we could add the cigarette tax and perhaps other taxes that we're not using at the present time.

The truth of the matter is that the Congress has acted, in my opinion anyway, contrary to the wishes of the American people in many respects. We seem to be behind public opinion. If we look at the situation the way it really is now, we know that several polls have been taken where the people seem to be ready for a national health plan. They want some of the things that we have done, including in the catastrophic bill, but not the way it was financed.

But nevertheless, we in the Congress have not been able to respond to the wishes of the American people.

What I'm saying, Mr. Chairman, is that I believe that the public in America is ready for a change. I think they're crying out for it and I think that now is the time to do it. I realize that what I am suggesting perhaps is not the solution to this problem, or the complete solution, and perhaps should not be used as the only solution. But we have enough thinkers in this Commission and in this Congress to come up with a solution that would make some sense. And I think that the time is now and that we should do it in a system that contains costs, but at the same time makes available to every American the care needed and paid for by every segment of the population of America, not just by the seniors.

Chairman ROCKEFELLER. Chairman Roybal, I appreciate very much not only what you have said, but what each of you have brought to this discussion in a panel which has brought together representatives of Congress and State government. We appreciate greatly the time that you have spent with us. We agree with you that the work that we're going to do is difficult, but important, and you've helped us very much. We thank you very kindly.

I'm going to call up the next panel and then I'm going to ask Jim Davis, one of our very valued Commission members, who has a statement. But let me first—Dr. Arthur Flemming, I believe, is not here yet. This next panel, panel 2, is consumer organizations and coalitions. They will be followed by panel 3, which is business; panel 4, which is providers; and panel 5, which is the insurance industry and consumer representatives, within the insurance industries that is.

Melvin Glasser is the director for the Committee for National Health Insurance. Lovola Burgess is vice president of the American Association of Retired Persons. Sara Rosenbaum is director of programs and policy of the Children's Defense Fund. Her boss is on the National Commission for Children. Steve Monson on behalf of the Consortium for Citizens With Disabilities. Eric Schulman, director of legislation, National Council of Senior Citizens. That's a very potent group. And I know that you'll wait just a moment because Jim Davis had a statement that he wanted to make and in my discourtesy I precluded him from making it. For which I apologize, Jim Davis.

STATEMENT OF COMMISSIONER JAMES DAVIS

Commissioner DAVIS. Thank you very much, Mr. Chairman. As a practicing physician, I am particularly pleased to have this opportunity to hear the views of the groups before us today who truly are at the forefront of the critical issues of providing adequate health insurance coverage for the many Americans who are uninsured and underinsured.

The situation we are addressing today is one in which the vast majority of Americans have health insurance coverage, either through a Government-financed program, such as Medicare or Medicaid, or through private health insurance. However, we are not blind and we must attend to the sad reality that too many of our citizens slip through the cracks.

There is no country in the world that is currently at peace with its health care system. They all have problems with financing and they all have problems with delivery of care. The United States, of course, has problems too, lots of them. Problems like rising health care costs, the 31 million uninsured, and problems like Medicare and Medicaid. But these problems and our other health care problems can be solved by building on the strengths of the American health care system. We need to develop our own unique American system that is compatible with our cultural expectations and our American values.

As immediate past president of the American Medical Association, I'm proud to have participated in developing AMA's plan to strengthen the health care system of this country, which would reform Medicaid so to provide medical care to all of the poor, instead of the 40 percent now receiving care; would establish State risk pools to provide access to coverage for those between 100 and 200 percent of the poverty line, with premium assistance for those between 100 and 150 percent; it would expand the employer-based health insurance to all employed Americans; and would develop a long-term care financing system encouraging public and private partnerships.

The physicians of America are very concerned about the barriers which prevent or impede access to vital health care services, in particular the fact that missions of Americans lack adequate health insurance coverage. We believe that the severity of the problem of the uninsured and the underinsured makes further Federal and State government action necessary. And Mr. Chairman, the physicians of this country consequently are committed to working with your Pepper Commission to make its goal a reality. Thank you very much, sir.

[The prepared statement of the American Medical Association follows:]

Statement of the American Medical Association

to the

"Pepper Commission"
United States Bipartisan Commission
on Comprehensive Health Care

RE: Providing Adequate Health Insurance Coverage
for the Uninsured and Underinsured

October 24, 1989

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STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION
to the
"Pepper Commission"
United States Bipartisan Commission
on Comprehensive Health Care

RE: Providing Adequate Health Insurance Coverage for the Uninsured and Underinsured

October 24, 1989

The American Medical Association takes this opportunity opportunity to present the views of the AMA on the important issue of providing adequate health insurance coverage for the many Americans who are uninsured or underinsured.

The situation we are addressing today is one where the vast majority of Americans have health insurance coverage either through a government financed program such as Medicare or Medicaid, or through private health insurance. Of the 181 million Americans who have private health insurance, about 80% or 141 million have employment-based coverage. For the most part, the existing system of health insurance coverage has enabled our citizens to gain easy access to a health care system and standard of care that is unequalled. However, we are not blind to the sad reality that too many of our citizens slip between the cracks, and steps need to be taken to prevent this situation.

Actions need to be taken to extend health insurance coverage to those currently uninsured and to establish a mechanism to assure the availability of access to essential health care services. This is not a simple matter, and the AMA carefully considered this issue before recommending that health insurance coverage should be provided, to the greatest extent possible, through the private sector for the uninsured and underinsured with incomes above the poverty level and through an expansion of Medicaid for the uninsured with incomes below the poverty level. The AMA reached this conclusion following a thorough analysis of the populations lacking health care insurance coverage and a review of alternative proposals to assure access to needed health and medical care.

Characteristics of the Uninsured

The number of uninsured Americans has increased significantly since the late 1970s when about 26 million people were uninsured. During the recession of the early 1980s, the number of uninsured increased dramatically, reaching about 34 million by 1983. Since that time, there has been some changing estimates of the number of uninsured, with estimates ranging from 31 to 37 million. The most recent estimates are that about 31 million are uninsured.

The uninsured are a surprisingly heterogeneous group. According to the National Medical Expenditure Survey (NMES) of the National Center for Health Services Research and Health Care Technology, the employed uninsured, with their dependents, accounted for 75% to 80% (about 24 million) of the uninsured population. Of the 24 million employed uninsured, 85% worked for firms of fewer than 100 employees, while 48% worked for firms of fewer than 10 employees. Many of the employed uninsured are low wage earners. About one-third earn $10,000 or less annually. Approximately 30% of the uninsured have incomes below the federal poverty level and another 30% have incomes between 100% and 200% of the poverty level.

It is estimated that about 1 million of the uninsured are persons who are considered to be "medically uninsurable." These persons are either unable to obtain health insurance coverage or can obtain such coverage only at extremely high rates because of poor health status, previous medical history, or employment in a medically hazardous occupation.

In addition to the uninsured, millions of other Americans lack adequate health insurance coverage. Thus, while these persons have health insurance, they may still be financially vulnerable and may lack access to necessary health care services.

Reasons for Increase in Number of Uninsured

The rise in the uninsured population is most often attributed to a combination of factors: Medicaid's failure to keep pace with the increase in the number of people in poverty; the high unemployment from 1980 to 1982 followed by shifts in employment away from manufacturing to relatively low-paying service-sector jobs; and increasing numbers of part-time workers.

While the number of persons on Medicaid has increased during the 1980s, the number of persons below the poverty level has risen even more sharply. As a result, Medicaid, which initially covered over 60% of the poor, now covers only about 40% of this group.

The number of Americans who are covered by employment-based insurance increased dramatically during the period from 1945 to 1979. While there has been a significant increase in the number of employed persons since 1980, the number of workers and dependents covered by employment-based health insurance has remained constant at about 141 million people. A reason frequently given for the increasing number of employed uninsured has been the major shift away from manufacturing jobs with high rates of employer-provided insurance and into the service and retail sales sectors that have lower rates of employer-provided insurance. There has also been a growth in the number of small businesses which frequently do not provide health insurance. In addition, there has been increased use of part-time workers who generally do not receive health insurance.

A final reason cited for the increase in the number of the uninsured is that fewer spouses and dependent children are being covered by employer health plans. Some plans just do not offer such coverage, and others make it too costly for many workers to afford. In addition, a growing number of workers who are offered and can afford coverage simply decline it.

The major reason that some businesses do not provide health insurance appears to be the cost of such coverage. The over 600 state mandated benefit laws are significant factors in increasing the cost of coverage. The cost of coverage is particularly high for small businesses which tend to be less profitable and face large administrative costs. In addition, small businesses that have employees in poor health may not be able to purchase coverage at any price.

Studies already indicate that the uninsured use less medical care than the insured, and that they are less likely to seek care when ill. As physicians, we are concerned that, with the U.S. health care system becoming increasingly competitive and cost-conscious, this situation can only become worse.

AMA Proposals

Because no single approach can adequately address the health care needs of all of the uninsured and underinsured, the AMA has developed a number of state and federal legislative proposals for extending adequate health insurance coverage to unprotected individuals. The proposals involve providing coverage through the private sector for the uninsured with incomes above the poverty level and through an expansion of Medicaid for the uninsured with incomes below the poverty level.

Coverage for the Employed Uninsured

The AMA supports the concept of phasing in a requirement that employers provide health insurance coverage within the private sector for all full-time employees. Requiring employers to provide health insurance would ensure coverage for the largest group of the uninsured, the employed uninsured. In our view, this requirement should be phased-in over several years and initially should apply only to larger employers. In addition, it is essential that tax credits or other tax benefits be provided for new and small businesses to avoid adverse effects on employers.

Expanding on the insurance coverage mechanism which has successfully assured access to high quality health care for the vast majority of Americans, with appropriate safeguards to prevent undue impacts on small and new business and protections to avoid interference with medical practice, presents the best alternative available for expansion of protection for many of the presently uninsured. The AMA recognizes the many valid concerns that small business has about required employer coverage and we believe that dialogue with the business community is essential in developing specifications for a program designed to expand employment-based health insurance coverage.

There is also strong public support for such an approach. According to the Employee Benefits Research Institute, 80% of surveyed Americans favored requiring employers to provide basic health care coverage. Seventy-five percent of those surveyed said they would still want employer provided coverage even if they had to pay federal income tax on the actuarial value of the plan.

Medicaid Reform

Expanding Medicaid coverage for those who are unemployed and in poverty also is a necessary and responsive step to guarantee access to health and medical care. About 11 million of the approximately 31 million uninsured persons have incomes below the federal poverty level. While the AMA, as a general rule, believes that health insurance coverage should be provided through the private sector rather than through an expansion of government coverage, we believe that government has a legitimate role in assuring access to health and medical care for those who are unable to help themselves. It is reasonable to propose that the Medicaid program should be expanded to assure coverage for those with incomes below the poverty level.

However, with expansion of Medicaid, the existing problems with the program will become even more apparent and they will need to be addressed. It is well documented that this program is fraught with problems and inequities, including: lack of coverage for about 60% of individuals with incomes below the poverty level; wide variation in eligibility criteria and benefits from state to state; and grossly inadequate physician and hospital reimbursement levels which restrict access to care.

The AMA believes strongly that the Medicaid program should be reformed to: (1) create a basic national standard of uniform eligibility for all persons below the federal poverty level (adjusted by state per capita income factors); (2) create basic national standards of uniform minimum adequate benefits; (3) eliminate existing categorical eligibility requirements; and (4) provide adequate physician and hospital reimbursement to assure broad access to care.

The AMA is aware that implementation of the above reforms would result in a significant expansion in the number of Medicaid beneficiaries and in the amount of state and federal spending under Medicaid. In our view, however, no other solution would adequately address the health care needs of the uninsured with incomes below the poverty level.

State Risk Pools

The AMA supports the enactment of state legislation that would establish a risk pool program to provide health insurance coverage both for the medically uninsurable and for those with medically standard risks who cannot afford individual coverage, but who could purchase coverage at near standard group rates with or without financial assistance. Fifteen states already have enacted risk pool legislation to create health associations that sell policies to high-risk, uninsurable individuals. These pools use a variety of mechanisms to make coverage available while spreading the cost of covering the medically uninsurable over a large population. The pool should provide a specified level of adequate benefits, with premiums set at a suggested level of no less than 110% or more than 125% of the average premium for comparable group coverage. States should provide publicly funded vouchers on a sliding scale to help persons with incomes between 100% and 150% of the poverty level pay the premium for pool coverage. Persons with incomes between 150% and 200% of the poverty level also would be eligible to purchase pool coverage at their own expense.

It is likely that the costs of expanded risk pool coverage would not be met totally through enrollee premiums. In that event, risk pool costs in excess of premium income should be spread as widely as possible. The AMA believes strongly that all health care underwriting entities in the state, including commercial carriers, non-profit medical service plans, health maintenance organizations, and self-insured plans, should be required to participate in the risk pool. By having all health underwriting entities participate, we believe that the pool would be assured a financial base sufficient to support the program and to achieve a fair sharing of the risks. Unfortunately, states currently are prohibited by the Employee Retirement Income Security Act (ERISA) from requiring that self-funded employee benefit plans participate in state risk pools. This prohibition creates strong barriers to effective operation of state risk pools since self-insured plans cover over half of the employee group benefit plans.

In order to achieve broad participation in state risk pools, the AMA has developed draft federal legislation that would amend ERISA so that states would regulate self-insured plans in the same manner that other health insurance plans are regulated, and self-insured plans would have to participate in state risk pools. The AMA also has developed draft federal legislation that would put teeth into this proposal by making the deductibility of employer health insurance premiums only available to employers who purchase group health insurance coverage from an entity that participates in the risk pools. If the employer is self-insured, it would have to participate in the risk pool directly. We urge that the Subcommittee and Congress give this proposal careful consideration.

The AMA supports the use of state tax revenues as an alternative to assessing the carriers participating in the pools for any excess pool costs over premium income. Using state tax revenues would spread pool costs over all state taxpayers rather than over only the policy-holders of participating carriers.

Temporary Extension of Coverage

Workers who are laid-off should have the opportunity to maintain employment-based health insurance for at least several months after their termination. As a result, the Association supported the provisions in P.L. 99-272 that require employers to make group health insurance available for terminated workers and their dependents at the worker's sole expense for an additional 18 months after lay-off. In addition, the Association supports requiring employers to offer to continue health coverage for laid-off workers and their dependents for up to four months after lay-off, with the employer and ex-employee continuing to pay the same percentage of the premium they had paid before lay-off. Enactment of such legislation would encourage laid-off employees to continue their health insurance coverage in their former employer's group health plan because they would not have to pay the full premium.

Open Enrollment Period, Pre-Existing Conditions

The AMA supports legislation that would require an employer's group health plan to provide an open enrollment period of at least 60 days for spouses of unemployed workers. In some two-income families, only one spouse may be enrolled in a group health plan. Currently, if that spouse becomes unemployed, the whole family would be without health insurance coverage. For open enrollment to be a true option, we also believe that pre-existing condition limitations should not be imposed on new enrollees. The American Medical Association supports legislation that would require true open enrollment to appropriately address this situation.

Deduction for Self-Employed Individuals

Currently, self-employed owners of unincorporated businesses can deduct as a business expense only 25% of the cost of premiums for their own health coverage. Owners of incorporated businesses can take a 100% business deduction for their own health insurance premiums if they provide coverage for their employees.

The AMA supports legislation that would allow all self-employed individuals to take a 100% business deduction for group health plan contributions paid for their own health insurance if they provide adequate health insurance coverage for their employees. Permitting self-employed individuals to take a full business deduction for their own group health plan contributions would encourage them to offer health insurance coverage to their employees and would create parity with incorporated businesses.

Encouraging Formation of Multiple Employer Trusts

The federal government should encourage the increased formation of Multiple Employer Trusts (METs). METs allow small employers to combine their buying power and spread their risks over a larger employee group. Encouragement of METs should result in more small employers being able to afford to either directly offer or to purchase adequate health insurance coverage for their employees. The AMA recognizes that those states currently not regulating the fiscal solvency of METs would need to enact appropriate legislation. In addition, a mechanism would be needed to ensure that METs purchase or provide adequate benefits. In our view, legislation should be enacted that would provide such a mechanism by amending the federal tax code to make the provision of adequate benefits a condition for an employer to deduct the cost of group health insurance premiums as a business expense.

State Indigent Care Funds

For those who would still not have adequate coverage, the AMA supports the establishment of state indigent care funds. The funds would pay health care providers in proportion to the amount of uncompensated care they render and would be financed from general revenues.

Conclusion

The AMA is very concerned about the fact that millions of Americans lack adequate health insurance coverage. The severity of the problem of the uninsured and underinsured makes further federal and state government action necessary. We have developed a number of proposals for extending adequate health insurance protection to the uninsured and the underinsured. Our proposals involve providing coverage through the private sector for the uninsured and underinsured with incomes above the poverty level and through an expansion of Medicaid for the uninsured with incomes below the poverty level. We urge the Commission to give careful consideration to these proposals.

Chairman ROCKEFELLER. Thank you, sir. Congressman Stark, did you have a statement?

Representative STARK. No, Mr. Chairman. I just didn't know that the AMA was on the witness list today or I would have.

Commissioner DAVIS. Maybe that's why the statement——

Representative STARK. I would suggest that they don't represent very many physicians, certainly not the responsible ones in this country, and I would just want to make the point that the AMA has never done much except to feather the economic nests of physicians in this country and I'll leave that stand.

Chairman ROCKEFELLER. As you can see, the Pepper Commission's coalition is rapidly developing, consensus is easy, under my brilliant leadership.

Now, Mel Glasser, let's start with you, if that's all right.

STATEMENT OF MELVIN A. GLASSER, DIRECTOR, COMMITTEE FOR NATIONAL HEALTH INSURANCE

Mr. GLASSER. Mr. Chairman, I'm Melvin Glasser. I represent the Committee for National Health Insurance. We have been in business 22 years to attempt to bring about effective reform of the health care system. And I welcome this chance to talk with you today, because you've already had before you ample evidence of the shortcomings of our system. The one correction I would make is there are 52 million people outside the system, not numbers in the thirties, as you have indicated.

The so-called safety net established through Medicaid covers less than half of those that are eligible. The net is shredded when Americans realize that to be eligible for Medicaid in the State of Alabama last year the income for a family of four could not exceed $1,416. In Texas the maximum permitted for eligibility was $2,208. Is it important, therefore, to recognize that last year close to 18 million people reported they were unable to get medical care when they needed it because they couldn't pay for it. That's a system which I would say the American people need to correct.

Our health care system is cruelly discriminatory against blacks and other minorities. The Secretary of Health and Human Services reported that if blacks had died at the same rate as whites, 42 percent of those who died before age 70 would not have. Translated that means nearly 60,000 excess black deaths each year in what we call a democracy. Blacks are dying at a higher rate than white counterparts from heart disease, stroke, cancer, infant mortality, and the newest epidemic engulfing all of us, AIDS.

Yet, despite the high rates of uninsured blacks and uninsured Hispanics, the majority of the uninsured under 65 is white. So that we have a situation which discriminates against minorities and also discriminates, if you please, against majorities.

Mr. Chairman, if I were to leave a single message with you this morning it would be, please, don't try again to resort to piecemeal, patchwork methods of dealing with the massive health care problem in this country. On this management and labor are coming together. Only last month Clark Kerr, the vice president and manager of corporate programs for the Bank of American said: "If I were rational I'd be totally pessimistic because everything we have tried has fallen flat on its face." And when there is more time, Mr. Chair, I'd be willing to discuss each and all of the patches that have been tried and failed.

Our committee, Mr. Chair, 4 years ago under the chairmanship of Douglas Fraser, appointed a committee under Rashi Fein from the Harvard Medical School with 12 experts for the purpose of designing a program which would be workable in the 1990's. That program is called the Health Security Partnership. When there is more time, I would be very glad to discuss the highly detailed specifics of how it can work and how it can be financed.

In the time allotted, I would only indicate this comprehensively financed program is based on these eight principles: Full access to all Americans. Benefits comprehensive enough to provide equal medical care for all, not separate and less equal in different systems. Three, meaningful cost-containment measures; there are eight of them built into the legislation. Four, specific provisions to maintain and strengthen the quality of health services. Five, simplified administration designed to eliminate waste, duplication, and inefficiency; 22 percent, Mr. Chairman, for administrative expenses in this country. No country approaches that in their figures. Six, provision for the beginning of restructuring the organization and delivery process. Seven, consumer participation to be assured in policy development with consumer recourse to organized grievance procedures. Eight, sufficient relationship to previous programs to insure evolution into new precepts and continued evolution in the future.

This partnership represents a new advance in national health program. It is both a national and a State plan. It provides for State and national budgeting. It provides for affecting improved quality through a number of health measures, including the development of guidelines to assure improving treatment effectiveness. It provides a role for the private insurance industry to play in a newly devised partnership with State government. And it should bring to a halt such practices as last year ordering 40 million procedures per day, at least 25 percent of which Secretary Sullivan recently indicated are probably of doubtful utility.

I would hope on another occasion, Mr. Chairman, when this Commission is able to devote more time to it, I might meet with you and the members of the Commission to outline more fully the specifics of a fully worked out program. Until then, I express my thanks to you and the members of the committee.

[The prepared statement of Mr. Glasser follows:]

TESTIMONY OF THE
COMMITTEE FOR NATIONAL HEALTH INSURANCE

Presented by

Melvin A. Glasser, Director

Prepared for the

U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

The Honorable John D. Rockefeller, IV

Chairman

October 24, 1989

Washington, D.C.

Members of the Pepper Commission, I welcome this opportunity to appear before you, if only briefly, to indicate the principles of a national health program designed to achieve the objectives set up by the Congress for your Commission.

You have already had before you testimony to the effect that America's system of public health services is in disarray. It has left some 52 million Americans with no health insurance at all or so little that it would not cover the payments for medical care for modest illnesses.

The so-called "safety net" established through Medicaid covers less than half of those who may be eligible. The net is shredded when Americans realize that to be eligible for Medicaid in the state of Alabama in 1988, the income for a family of four could not exceed $1,416. In Texas, the maximum permitted for eligibility was $2,208, and in Ohio, it was $3,708. Last year more than 18 million people, in response to a Harvard School of Public Health and Lou Harris and Associates national survey, reported they failed to get medical services they needed because they just couldn't afford the care. Many have greeted with disbelief the information that approximately one million Americans each year are losing health insurance protection.

There has been a sea change in public attitudes. Only 10 percent of the people surveyed in the past year think the health care system works "pretty well". Nearly 90 percent of all Americans polled think our system needs fundamental change. On a personal basis, 45 percent of Americans surveyed are not happy about their last experience with a doctor.

Our health care system is cruelly discriminatory against Blacks and other minorities. The Secretary of Health and Human Services reports that if Blacks had died at the same rate as Whites, 42 percent of those who died before age 70 wouldn't have. Translated, this means nearly 60,000 excess Black deaths each year. Blacks are dying at a higher rate than their White counterparts from heart disease, stroke, cancer, infant mortality, and the newest epidemic engulfing us all -- AIDS infections.

The importance of health insurance is underlined in a report of a recent study in the New England Journal of Medicine which concludes: "Babies whose parents lack health insurance are 30 percent more likely to die at birth or be born seriously ill than insured babies." The increased vulnerability is especially high in uninsured Black and Latino babies.

Yet despite the high rates of uninsured in the Black and Hispanic populations, the majority of the uninsured under 65 is White. And 16 percent of family members were in families with at least one working adult who had no health insurance.

If I were to leave a single message with you this morning, it would be "Please don't try again to resort to piecemeal, patchwork methods of dealing with the massive health care problem in this country." On this, management and labor are largely coming together. Only last month, Clark Kerr, Vice President and Manager of Corporate Programs for the Bank of America, said: "If I were rational, I'd be totally pessimistic, because everything we've tried has fallen flat on its face."

The Committee for National Health Insurance, a coalition of national organizations representing major unions and other national groups, recognized some four years ago that the disintegration of health care plans in America had reached a point where the staggering costs, combined with decreasing coverage, inefficiency, waste, and poor quality, was undermining health services delivery to the point that comprehensive major change was essential. Chairman Douglas A. Fraser appointed an expert group, led by Professor Rashi Fein, of the Harvard Medical School, for the purpose of studying the problem and arriving at a comprehensive, rather than patchwork, answer to the question of how to make decent health care available to all. This has taken the form of the **Health Security Partnership** plan. It is based upon eight principles:

1. Full access to all Americans.
2. Benefits comprehensive enough to provide equal medical care to all.
3. Meaningful cost containment measures built into the plan.
4. Specific provisions to maintain and strengthen the quality of health services.
5. Simplified administration designed to eliminate waste, duplication and inefficiency.
6. Provisions for the beginning of restructuring the organization and delivery process.
7. Consumer participation to be assured in policy development with consumer recourse to organized grievance procedures.
8. Sufficient relationship to previous programs to ensure evolution into new plans and continued evolution in the future.

The **Health Security Partnership** represents a new advance in national health programming. It is both a national plan and a state administered and partially financed program. It provides for state and national budgeting and, through twelve legislated provisions, assures immediiate cost containment and improved restraint of costs in subsequent years. It makes possible effecting improved quality of care through a number of measures, including the development of guidelines to assure improving treatment effectiveness.

It provides a role for the private insurance industry to play in a newly devised partnership with state government.

And, it should bring to a halt such practices as ordering 40 million tests each day, as occurred in this country only last year, and as many as one-fourth of them, according to the Secretary of Health and Human Services, being of doubtful utility.

I would hope on another occasion, Mr. Chairman, when this Commission is able to devote more time to it, I might meet with you and the members of the Commission to outline more fully the specifics of our Committee's plan. We believe it offers an equitable, cost-contained, consumer-oriented approach to national health care which is urgently needed in this country today.

Chairman **Rockefeller**. Thank you very much. Ms. Burgess, before I call on you I'd just like to point out for the interest of those who are listening, that deciding who would be on these five panels was incredibly difficult. We had over 75 organizations who wanted to testify at this particular hearing. And so, to those who are testifying, I say well done.

To those who aren't testifying, I say that the fact that you aren't is simply a factor of time. Five panels, you know, until 1 p.m., is really about all we can do and we apologize, I sincerely apologize to each and every one who was not able to testify. Please don't feel that your words, your advice, letters, written statements, or whatever, will not be very, very welcome by us. Obviously they are, but at some point we just had to make a smaller number of participants.

Lovola Burgess representing the American Association of Retired Persons.

STATEMENT OF LOVOLA BURGESS, VICE PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Ms. **Burgess**. Good morning. My name is Lovola Burgess and I'm from Albuquerque, NM. I'm vice president of the American Association of Retired Persons [AARP]. I'm pleased to be here today to discuss with the Pepper Commission how we can lay out a plan for the future of health care in this country, a plan that will mean that Americans will not have to go without basic health and long-term care services.

Despite our Nation's extraordinary resources and abilities, we have no national plan to meet growing health and long-term care needs, nor do we have a national plan to insure the quality and affordability of that care. AARP support for universal access to health care is, as you may know, long standing, going back to advocacy for national health insurance in the late 1970's.

More recently, our board of directors has reiterated this commitment, calling for the development of a comprehensive plan that would provide access to health care for all Americans. Such a plan will have to respond realistically to the complexity and the cost of our health care system and it's not an easy task for the Commission or for AARP.

A comprehensive approach requires that we look at the benefits that will be provided, the way in which services are delivered, their quality, and how they are priced and financed. It is important that we examine a range of options, that we draw upon the experience of other countries, our own private sector, and the strengths of health care programs like Medicare that are already in place. It will also be important that we not shy away from the hard work of starting from scratch to build a system that integrates access, quality, and affordability.

While we need to have a longer term blueprint, we must not lose sight of the immediate need of millions of individuals for health care. The Commission can help relieve the critical problems we face today by spotlighting those incremental steps that move us toward a larger solution.

AARP supports expansions in the Medicaid Program as the most likely opportunity to insure that poor persons, regardless of their age or circumstance, have health care coverage. Building upon our current employer-provided health insurance system, the association also supports requiring employers to continue health care coverage for individuals who must take time off for a temporary medical disability of the family.

My written statement lists a number of other short-terms strategies for expanding Medicare and Medicaid, employer and individual coverage, and protecting individuals from abuses in the insurance marketplace that deserve further exploration.

Addressing the need for long-term care among persons of all ages is another critical task of the Commission. AARP recommends a social insurance approach that protects all Americans from impoverishment and lack of care. Social insurance would require financial contributions from all members of society and would provide protection to all who need long-term care.

Our country's primary governmental long-term care program, Medicaid, was not designed for that purpose. Reliance on it forces us to cut back on other critical health care services for the poor. It limits long-term care coverage to nursing homes, providing little or no coverage for the home care that most older Americans say they would prefer, and our beloved Senator Pepper certainly stressed that.

The private insurance market has begun to offer long-term care insurance policies, which can help meet some of the need for protection against the cost of long-term care. This kind of supplementary protection will be essential, much as private pensions are important in conjunction with the Social Security system. But it cannot be regarded as the solution.

In view of the limitations of both Medicaid and the private sector and the strengths of our Social Security Medicare and programs, AARP believes that the primary answer to the long-term care financing dilemma lies with the public sector in a social insurance approach that would spread the cost or risk of extraordinary long-term care costs across the broadest possible population.

In conclusion, our Nation's health care system is not working properly and we have indicated that so many times this morning. We pride ourselves on being one of the richest countries in the world, but your citizens go without the basic health and long-term care services. We are already paying the cost of this care, but in a very uneven way. Some of these costs register in the Federal budget, others do not, but they are all real costs to society.

The answer must lie in a comprehensive approach which recognizes the complexity of the system and the interdependence among its many parts. This Commission can design a blueprint which extends protection to all, which provides long-term care coverage to all who need it, and contains the cost of health care. AARP looks forward to working with you and the Congress and the administration on the agenda, which is certainly very ambitious. Thank you.

[The prepared statement of Ms. Burgess follows:]

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

HEALTH CARE OPTIONS

Presented by:

Lovola Burgess
Vice President

before the

PEPPER COMMISSION

October 24, 1989

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
Louise D. Crooks *President* Horace B. Deets *Executive Director*

The American Association of Retired Persons (AARP) welcomes the opportunity to discuss challenges facing America today concerning access to health and long-term care services. We commend the Pepper Commission for holding these important hearings.

The importance of this Commission's work is clear. Our nation's recognized achievements in health care are diminished by our failure to guarantee access to basic medical and supportive care services for all our citizens. Last year over $550 billion dollars was spent on health care in the U.S. Yet, even though this represents more per capita and as a percentage of the GNP than any other country in the world, serious barriers to basic care exist. Over 34 million Americans have no health insurance coverage, and millions more have inadequate protection. We have no system to assure access to or cover the costs of long-term care, forcing individuals to spend from their savings and income or to rely on Medicaid, a poverty program. Residents of rural areas face shortages of physicians, nurses and other health providers, transportation problems, and hospital closings.

These problems have serious implications for individuals, families and for society as a whole. The lack or inadequacy of insurance forces many people to delay or avoid receiving routine or preventive health care. This problem not only harms an individual's health, but increases public expenditures when delay in treatment leads to expensive emergency care or hospitalization. The lack of a comprehensive system to finance long-term care forces some chronically disabled individuals to go without services. It also burdens family caregivers and friends, impoverishes individuals and families, and stretches Medicaid budgets. In a program that was not intended for this purpose, long-term care spending accounts for over one-third of Medicaid expenditures. Finally, the scarcity of health care providers and facilities in some rural and inner city areas severely impedes access to essential health care services, such as prenatal care and emergency services.

As we discuss the future direction of our health care system, it is critical to recognize that the costs of health and long term care are now borne by society, but in a very uneven way. Some of these costs register in the federal budget, others do not; but they nonetheless represent real costs to society. By the same token, an increased public role that would help to spread costs in a more affordable manner across the population, while assuring all Americans access to care, does not imply that society's costs have risen.

This is a nation of extraordinary resources and abilities. Yet, we have no national plan to meet growing health and long-term care needs or to ensure the quality and affordability of that care. It is AARP's hope that through the work of the Pepper Commission a blueprint for the future of health care in this country will be developed. The Association is strongly committed to a comprehensive approach to providing affordable health and long-term care for the people of the United States, regardless of their age.

IMPROVING ACCESS TO HEALTH CARE SERVICES: AARP ACTIVITIES

Assuring that persons of all ages have access to needed health care services is integral to true reform of our health care system. Surveys indicate that Americans view health care as a right, and that the public overwhelmingly supports extending coverage to all who are uninsured.

The Association's ongoing interest in universal access to health care is long-standing, going back to advocacy for national health insurance in the late 1970's, and reflected, more recently, in policies adopted by its Board of Directors over the past two years. In 1988, the Board called for the development of a more comprehensive Association policy position that could move the country toward the goal of universal access to health care. Even while this policy development is underway, the Association has also committed its resources to the education of our members and the public at large on the critical necessity of reforming our health care system to ensure access to health care for all Americans.

Further, the Association is funding several related studies including an exploration into the number of uninsured by state, the implications of employer-mandated benefits for low-wage workers and low-margin employers, and the use of demographic characteristics in small group rating practices.

AARP has long supported legislative initiatives to improve access to health care services for the underserved, including support of expanded Medicaid coverage. Most recently, this has meant our strong support for:

- expanded Medicaid coverage of pregnant women and children;
- the Medicaid buy-in to Medicare for poor Medicare beneficiaries; and
- legislation to make the 2176 Home and Community-Based Waiver Program an option for the states, which we hope to see enacted this year.

AARP has also been active at the state level, promoting efforts to: (1) create programs for the uninsured: (2) expand and improve Medicaid; (3) establish health care data collection systems that can monitor and compare cost and quality; and (4) provide incentives for health care providers to practice in rural areas.

THE NEED FOR COMPREHENSIVE REFORM OF OUR HEALTH CARE SYSTEM

From research, education and advocacy efforts on this and other health care issues, we have learned that the many serious problems facing our health care system cannot be solved in a piecemeal fashion. Simply broadening access to insurance coverage will not help control the relentless increases in health care costs that threaten the solvency of the entire system. Nor will it assist those living in rural areas who may not have a physician or hospital in their community.

Rather, the answer must lie in a comprehensive approach that recognizes the complexity of the system and the interdependence among its many parts. As we broaden the issue beyond coverage, we must address both the way in which health care services are delivered and how such services are priced and financed. Our best efforts will be compromised, however, if we do not also work to improve the appropriateness and efficacy of medical care. A comprehensive approach must also address the most pressing issue for many older Americans: the lack of coverage for essential long-term care services.

SHORT TERM STEPS TOWARD A LONG TERM SOLUTION FOR THE UNINSURED

The critical need for comprehensive reform of our health care system coupled with the immediate need of millions of individuals for adequate health care requires that public policy advance simultaneously on several fronts. This Commission can provide for reforming and shaping our health care system over the next decade. It can also spotlight those incremental steps that move us toward a larger solution.

The Association supports expansions in the Medicaid program as the most likely opportunity to ensure that poor persons, regardless of their age or circumstances, have health insurance coverage. Several necessary improvements in the Medicaid program include:

- Deeming all people living at or below the Federal poverty line to be eligible for Medicaid, without regard to their eligibility for government cash assistance programs. States should have the option to exceed the minimum standard and to phase-in increases in the eligibility level.
- Requiring all states to have medically needy programs for people of all ages.
- Adjusting Medicaid's physician fee schedule to ensure adequate access to the services of primary physicians specialists.

In other areas, the Association continues to urge that employers be required to continue health care coverage for individuals who must take time off to care for a temporary medical disability in the family.

Other incremental steps that have been suggested include:

Expansions of Medicare

- Coordinate Medicare coverage with the benefit continuation provided by Title X of COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) so that COBRA coverage would extend to 29 months for persons ending work as a result of disability. This extension would carry beneficiaries to the end of their Social Security Disability Insurance (SSDI) waiting period. (COBRA requires that someone leaving employment be permitted to continue purchasing insurance through the employer group for 18 months).

- Permit early retirees who do not have health insurance through their former employers to purchase Medicare coverage. This option could be tied to the receipt of benefits under Social Security early retirement, or could cover any age of early retirement. An estimated 990,000 early retirees had no health insurance coverage in 1986. Of these, 589,000 were between the ages of 62 and 65.
- Reduce the two-year waiting period for Medicare coverage after a person has been determined to be eligible for the Social Security Disability Insurance cash benefit.

Medicaid Expansion

- Permit uninsured individuals to buy into Medicaid, with premiums based on their ability to pay.

Employer Coverage

- Establish a federal financial incentives program for small employers (with fewer than 10 or 20 employees) to assist them in providing qualified health insurance plans to their employees.
- Allow a higher deduction for health related expenses for

self-employed individuals. Currently only 29 percent of sole proprietorships with less than 10 employees have coverage, while 70 percent of similarly sized incorporated businesses have health insurance.

- Allow early retirees and their dependents to buy into their former employers' plans until the retirees become eligible for Medicare.

Individual Coverage

- Provide federal financial incentives, such as tax credits or direct payments, to assist uninsured individuals to buy coverage from qualified health plans.

Insurance Marketplace

- Create regional insurance pools to offer affordable, stable coverage to small employers and individuals.
- Provide incentives for HMO's and other managed care arrangements to offer products to small business and individuals.
- Prohibit certain forms of underwriting practices which exclude those most in need of coverage from the group or make coverage unaffordable over time.

THE POPULATION IN NEED OF LONG-TERM CARE

People of all ages may find themselves in need of long term care. Today, seven million American households have a child or adult member who is chronically ill or disabled. As medical technology advances, many people who need long-term care are living longer than they would have in the past. For example, children with lung disease are now able to live for years with the assistance of a respirator. As people age, they frequently fall victim to chronic illnesses such as Alzheimer's disease. More than 2.5 million Americans suffer from Alzheimer's disease and related conditions. Most victims are age 65 or older, although many people under age 65 are afflicted.

The need for a new system of long-term care extends beyond those who need the care to those--family and friends--who provide personal care and financial support. Family members are the cornerstone of the long-term care delivery system. These caregivers typically provide care every day.

The caregiver's responsibility is evident in data from a 1989 report by the Commonwealth Fund which shows that 83 percent of impaired older people live with a spouse, family member, or companion who provides informal care. Only 17 percent of impaired older people live alone, compared with 30 percent of the general older population. Further, the 1982 National Long Term Care Survey indicated that almost 3 out of 4 functionally impaired older Americans rely exclusively on unpaid care provided by families and friends; another 21 percent rely on a combination of support from families and paid providers. Only 5 percent of older people rely solely on paid providers.

The people most at risk of needing long-term care are older women who are widowed. Women over age 65 now outnumber men over age 65 by a ratio of 1.5 to 1 and most older women are widows. Additionally, since many older people have incomes close to the poverty level, many of these older, widowed women are poor.

Perhaps most important of all are the hidden costs of suffering, deprivation, and isolation for those in our society who get no care or inadequate help. Data from the National Long-Term Care Survey indicate that large numbers of functionally impaired older persons in the community, particularly the severely disabled, have unmet needs for assistance. For example, 77 percent of older people with three or more limitations in their activities of daily living reported they needed more help.

The need for long-term care leads almost inevitably to an unmanageable financial burden because the cost of care is often enormous. Estimates of the average cost of a year in a nursing home range from $25,000 to $34,000. Nursing home stays account for over 80 percent of the expenses incurred by older people who experience very high out-of-pocket costs for health care. Since few people can afford the expense of an extended nursing home stay, many end up on Medicaid after a financial catastrophe has occurred. While Medicaid picks up a substantial share, more than half of nursing home costs are paid out of the pockets of residents and their families. The family's share of this burden has been rising in recent years.

RECOMMENDATIONS FOR A NEW LONG-TERM CARE SYSTEM

Our country's primary governmental long-term care program, Medicaid, is inadequate for several reasons: 1) the Medicaid program does not cover home care except through special waivers; 2) among the services which Medicaid can provide, the degree of coverage varies dramatically from state to state; 3) because it is a welfare program, Medicaid often robs families of dignity and independence; and 4) Medicaid does not enjoy the public or political support of programs from which everyone benefits, such as Social Security or Medicare.

The question before us is how to spread the burden so that the costs to any one person will be small, while offering protection and appropriate care to all. The answer is a social insurance, rather than a welfare, approach.

The nature of the need for long-term care lends itself to an insurance approach based on shared risk for several reasons: 1) relatively few persons in our society need long-term care at any one time; 2) it is nearly impossible to predict who these individuals will be; and 3) the lifetime risk of needing nursing home care is much higher than most people think. (For a person who is 65 years old, the risk of institutionalization during the remainder to his/her life ranges from 36 percent to 63 percent.) This combination of factors shows the need for and the utility of a social insurance approach to universal protection. The costs to any one person will be small, while offering protection to all against financial devastation.

Americans of all ages recognize that long-term care is a growing necessity. While many underestimate the costs and the likelihood of their needing such service, our history with Social Security and Medicare, as well as public opinion polling on long-term care demonstrate that the public supports a social insurance approach.

Access, affordability and quality are all fundamental to a long term care program. Access to necessary services at an affordable cost is best provided through a system that is available to everyone and which spreads the risk of very high costs across a broad population. Assuring quality of care will require not only adequate reimbursement and monitoring, but also the availability of qualified personnel. Recent evidence from the nursing home and home health industries indicates that both nursing homes and home health agencies have difficulty recruiting and retaining nurses and aides.

Some specific recommendations for a long term care program include:

Eligibility

Americans of all ages should have access to a new long-term care program. Chronically ill children and adults, as well as permanently disabled people, need access to long-term care.

Eligibility for benefits should be based both on cognitive and functional impairments. Many people may be physically capable of performing activities of daily living but unable to do so because of cognitive impairments. In determining eligibility for the program, in-person assessments of the beneficiary as well as interviews with caregivers will be critical to gathering accurate information about individuals' functional status and service needs.

Benefits

AARP advocates that a long-term care program offer a wide range of long-term care services in the least restrictive setting possible. Services should include in-home assistance (including provision of home care services in special housing), community services, and high quality institutional care. Respite care, which serves the critical function of providing short-term relief to unpaid caregivers should be a component of a long-term care program as well. A broad range of services ensures that people receive care that is tailored to their needs and circumstances. This also allows the most efficient use of resources.

Since our current federal long term care obligations are heavily biased toward nursing home coverage and since there is a strong preference for services which maintain people's independence, the first priority for program expansion should be in the area of home and community services.

Administration

The Federal government should take a strong role in administering the long-term care program to ensure that consistent standards for eligibility, quality of care, and reimbursement are maintained nationwide. Service delivery systems and the profiles of populations needing long-term care vary widely between and within the states. Thus, states will need to have some flexibility to tailor programs to meet their residents' distinctive needs.

While the federal government has a very strong oversight responsibility and the states have a role in administering a new long-term care program, care management agencies have the potential to make the program work at the local level. (Care managers assess clients' needs for long term care services and then help arrange their delivery.) Care managers could have responsibility for determining program eligibility and beneficiaries' needs for care; developing the appropriate plan of care; arranging for delivery of services; and helping to ensure quality of care. Care management holds promise both for helping people to secure appropriate services as well as for controlling use of services. Appropriate use of services is the key to keeping utilization and program costs under control. More research is needed to determine the best care management models and the appropriate role of these agencies.

Provider Reimbursement

Provider reimbursement systems for long-term care services should be designed to ensure the delivery of quality care. They should also ensure that cost increases in the program are rational and controlled. Toward this end, a prospective payment reimbursement system would be effective. Reimbursement should be acceptd as payment in full so that providers do not try to overcharge residents or clients.

States, through their nursing home reimbursement systems, have begun to deal with these issues, and their experiences should be examined for applicability to a federal system. For example, a number of states have developed "casemix" reimbursement systems that are designed to encourage nursing homes to accept heavy-care patients and deliver appropriate amounts of care. New York's resource utilization group system (RUGS) pays nursing homes according to the amount of resources necessary to care for residents. Other states, such as Oregon, are beginning to develop nursing home reimbursement systems that would relate payment levels to resident outcomes.

With regard to payment for home care, there is less of a track record at the state level. In this area, research should focus on prospective payment that accounts for casemix and outcomes.

Quality Assurance

Under a new long-term care program, the federal and state governments should take a more aggressive role in the assurance of quality care. Additional quality standards for provider participation in the long-term care program should address the following goals: 1) plans of care and actual services delivered must meet client and caregivers' needs; 2) providers should not be allowed to discriminate in admissions or service delivery on the basis of payment source; and 3) social isolation of clients should be prevented. In addition, care managers should elicit clients' views of the quality of care, and state ombudsperson programs should be expanded to have responsibility for investigating and resolving complaints about all types of long-term care providers.

The Role Of The Private Sector:

Private sector options for financing long-term care include private long-term care insurance, home equity conversion plans, and the prospect of long-term care individual medical accounts. Although long-term care insurance offers some promise as a way to augment a federal social insurance program, it is still in its infancy and there are major barriers to its development. While the number of policies in force (estimated at 1 million) is growing, they cover few of the 51 million Americans aged 55 and over. Projections by the Brookings Institution indicate that the proportion of total nursing home care financed through private insurance by the years 2016-2020 will be between 7 and 12 percent at most, given favorable assumptions.

This finding is based principally on barriers that are likely to limit the usefulness of long term care insurance policies to the public. Such barriers include:

- the cost of the policies;
- limitations and restrictions in coverage;
- the lack of inflation protection;
- the existence of prior institutionalization requirements as a condition of benefit coverage;
- the lack of adequate home care benefits; and

- consumers' lack of knowledge about the need for protection against long-term care expenses.

In addition, people in need often cannot purchase private long-term care insurance. Few companies will sell insurance to people age 80 or over, or to people with pre-existing (potentially disabling) medical conditions. This practice may be necessary to maintain the financial stability of the insurance plan, but it leaves those most likely to need long-term care without any protection.

Due to the private sector's limitations, AARP believes that the primary answer to the long-term care financing dilemma lies with the public sector. Under a social insurance system, private sector approaches should supplement the public system by covering copayments, deductibles, and extra services. Private sector approaches should be subject to federal oversight and strong consumer protection standards.

Financing The New Long-Term Care Program:

A long-term care program that addresses the needs of current retirees and builds an adequate program for future generations will require a range of financing sources. The program must be adequately financed so that it does not increase the federal budget deficit. A financing package should take into account the fact that people at or near retirement would be eligible for benefits before a large reserve fund could be built up. In order to adequately fund the program for future generations, it, like Social Security and Medicare, should be based on social insurance principles. By spreading the cost across the entire population, protection could be provided in a more affordable, equitable manner for any one person.

Older Americans and the working population will each have to pay a portion of the costs of a long-term care program, both in its early phase and for future generations. Revenue from older Americans could come from sources such as higher estate and gift taxes. Modest premiums might be used, but an actuarially sound contribution to buy protection against long-term care costs is simply too expensive for most older Americans. In addition, since any system would likely have some cost-sharing requirements (copayments and deductibles), older Americans would be asked to contribute in this way. Such cost-sharing should, however, reflect the fact that they are already paying substantial premiums for acute care protection under Medicare.

Revenue contributed by the working population should be from taxes that could be earmarked to a trust fund to build adequate reserves to protect younger generations, making payroll taxes a likely option. This could be accomplished through broadening the tax base by uncapping the wage base on the Medicare Hospital Insurance trust fund and by a small increase in payroll tax rates. This method would allow substantial reserves to accumulate and ensure benefits for the "baby boom" generation. To reassure people under 65 that this is a program for their later years, the fund should be phased-in so that benefits flow primarily to future retirees.

The Association opposes means-testing deductibles, co-payments or eligibility for long-term care benefits under an expanded Medicare program. Flat beneficiary co-payments for either community-based or institutional care services should be modest. People with low incomes should be protected against cost-sharing through an expanded Medicaid-type program, which could be partly financed through general revenues.

CONCLUSION

All Americans are adversely affected by the high cost of health care and insurance, the lack of insurance or the prospect of becoming uninsured, the lack of long-term care protection and other factors which limit access to essential health care. Our nation's health care system is not working properly and bold action must be taken. In a nation that prides itself on being one of the richest countries on earth, every citizen should be able to receive basic affordable health and long-term care. The answer must lie in a comprehensive approach that recognizes the complexity of the system and the interdependence among its many parts, including both the way in which health care services are delivered and how such services are priced and financed.

In closing, we urge the Pepper Commission to design a comprehensive blueprint for the future of health care in America which extends insurance protection to all, provides long term care to all who need it, and contains the cost of health care. AARP looks forward to working closely with the Pepper Commission, Congress and the Administration to solve the health and long-term care crises facing America.

Chairman **Rockefeller**. Thank you, Ms. Burgess, very much for that.

Ms. Rosenbaum for the Children's Defense Fund.

Ms. **Rosenbaum**. Thank you very much, Mr. Chairman.

Chairman **Rockefeller**. Can you pull that microphone up as close as you can?

Ms. **Rosenbaum**. Yes.

Chairman **Rockefeller**. Thanks.

STATEMENT OF SARA ROSENBAUM, DIRECTOR OF PROGRAMS AND POLICY, CHILDREN'S DEFENSE FUND

Ms. **Rosenbaum**. Over the past several years, chiefly because of the work of many of you who now serve on this Commission, a number of important gains in health programs for low-income children have been made. These incremental gains have been made by carefully and slowly restructuring some of the most important publicly funded health programs for financing and delivering health care to low-income and medically underserved children and families.

Despite these improvements, the overall insurance and service delivery situation is disintegrating faster than gains can be made. For example, between 1984 and 1987 the total number of children enrolled in Medicaid nationally increased by about 600,000. During the same time period, however, the number of children with employer coverage dropped by about 1.2 million. So, for every child added to Medicaid during the mid-1980's, two lost employer coverage.

As it approaches the end of the century, the Nation is at a crossroads. We can continue to work year after year, as many of us have, for modest and incremental reforms in children's health care financing, financing programs for the poor, and programs to serve the medically underserved. But this will not fix the fundamental problems plaguing the system. In sorting through the range of more fundamental remedies available to the Commission, the most important task will be insuring that the remedies are directed at the problems at hand.

Since the two largest groups of uninsured Americans are children and young adults, the Commission's proposals must deal squarely with them. In 1987 children under age 18 and young adults 18 to 24 comprised 37 percent of the U.S. population as a whole, but more than 50 percent of the uninsured. These young adults are not simply unemployed youth or college students. They include more than 10 million young women of childbearing age, as well as millions of young parents many of whom are working at their first or second jobs. The types of young families most likely to have children are also those who are least likely to have gone beyond a high school education, meaning that they are permanently in a position of earning lower wages.

A key question, therefore, is how effective an employer mandate will be for them. It is true that the vast majority of uninsured children and young adults are members of working families. However, these families are the most likely to work at low paying jobs that are temporary or part time in nature or for very small firms. They're also more likely to change jobs with more frequency.

This obviously does not mean that an employer mandate may not be worthwhile. It does mean, however, that focusing most time and energy and legislative resources on such a mandate runs the risk of replicating what has occurred before; namely, a residual public system suffering from a lack of time, energy, and money, conceived as an afterthought rather than as a primary source of insurance, even though it has millions of beneficiaries. Moreover, it bears all the defects and possible stigma of a system for the poorest, weakest, and least attached to the labor force.

Therefore, in constructing a comprehensive remedy to aid the uninsured, it is essential to bear in mind that the public companion that you create, if a companion is a remedy that is to build on an employer mandate, will be as important to the currently uninsured as the private side of the plan would be. In formulating a program for uninsured children and young adults we think that a number of principles are of central importance.

First, the program should be universal and not means-tested or residual. It should be a program which is open for everybody to enroll in.

Second, the program must be capable of responding to maternity and pediatric health needs that are not traditionally considered insurable, including both preventive benefits and maternity benefits, as well as benefits that are therapeutic in nature and designed to deal with children with developmental delays and other disabilities.

Third, the adequacy of lower income pregnant women's and children's health care depends not only on having sufficient insurance, but also on having access to providers capable and willing to furnish services geared to all families' needs. And therefore, part of the funding should be spent on health resources development which is ever more critical.

I should note that 10 years ago we had about 3,500 National Health Service Corps doctors to place in manpower shortage areas. By 1994 we will have placed the last two. I do not know how about 500 community and migrant health centers are going to keep going after that point. They now serve over 3½ million children and in total about 6 million medically underserved Americans.

Fourth, the services and benefits should be funded through a mix of third-party payment for services provided, as well as prospective grants to providers to develop services where they are needed.

And finally, universal coverage should be accompanied by a major expansion of those programs that have proved so effective in developing appropriate services, specifically community and migrant health centers, the National Health Service Corps, immunization grant programs, family planning, and title 5. Thank you.

[The prepared statement of Ms. Rosenbaum follows:]

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DEAR LORD
BE GOOD TO ME
THE SEA IS SO
WIDE AND
MY BOAT IS
SO SMALL

TESTIMONY OF THE CHILDREN'S DEFENSE FUND BEFORE THE UNITED STATES BIPARTISAN COMMISSION ON HEALTH CARE (THE PEPPER COMMISSION)

Presented by

Sara Rosenbaum
Director, Programs and Policy

October 24, 1989

The Children's Defense Fund is a national public charity that provides long range and systematic advocacy on behalf of children. We pay particular attention to the needs of low income, handicapped and minority children. For more than 15 years we have worked to improve the health of poor children by ensuring that they and their families have access to the basics that any child needs to be born healthy, thrive, and grow into productive adulthood: adequate family income, a safe place to live and a safe neighborhood to grow up in, good schools, a caring and nurturing family, and access to decent health care.

Most of us take these as givens for our children. But for one in five American children and one in three children living in young families (those whose family head is under age 30), family poverty means that these fundamentals are not a given. Today a poverty of enormous magnitude and depth grips American children. If its causes remain unaddressed, then by the year 2030, a third of all of U.S. children will be living in poverty.

Over the past several years chiefly because of the work of many of you who now serve on this Commission, a number of important gains in health programs for low income children have been made. These incremental gains have been made by carefully and slowly restructuring some of the most important publicly-funded health programs for financing and delivering health care to low income and medically underserved children -- Medicaid, Community and Migrant Health Centers, the Title V Maternal and Child Health Services Block Grant and the federal immunization grants program.

Congress has expanded the Medicaid program to make possible coverage of all pregnant women and infants under age one with family incomes below 185 percent of the federal poverty level and all children under age 8 with family incomes below 100 percent of the federal poverty level. After disastrous reductions at the beginning of the decade, some funding has been restored to Community and Migrant Health Centers, which serve more than 5 million of America's 25 million medically underserved urban and rural residents, as well as to the Medicaid, Title V and federal immunization grants program.

We estimate that, if fully implemented, the expanded Medicaid option to cover pregnant women and infants will reduce the number of such uninsured women and their babies by some two-thirds nationally, while the option to cover poor children will reduce the number of such uninsured children by about a third. And expanded public health service delivery programs will help ensure that actual health care reaches the children for whom insurance alone is not enough. We also are exceedingly hopeful that by the end of the year Congress will enact important Medicaid legislation, building on these previous expansions, which has been passed by the House of Representatives and adopted by the Senate Finance Committee.

Taken together, these reforms will produce swifter assistance to more pregnant women and children, promote greater stability for publicly funded clinics (a disproportionate share of whose patients are publicly insured or completely uninsured), and perhaps promote greater Medicaid participation among private obstetrical and pediatric providers. In all these reforms will cost the federal and state governments slightly more than $3 billion over the next 3 years -- about 2 percent of the at least $166 billion that the nation will pay over the next 10 to 20 years to bail out insolvent savings and loan institutions.

Despite these improvements, the overall insurance and service delivery situation is disintegrating faster than gains can be made. Even with its recent expansions, Medicaid still fails to cover most families with incomes below the federal poverty level. Publicly funded health service programs are now financed in real dollar terms below their Fiscal 1981 funding levels, even though the proportion of uninsured Americans has climbed by nearly 20 percent over this decade. Such vital programs as the National Health Service Corps, which at the beginning of the decade had more than 3300 scholars to place in manpower shortage areas have been terminated. By 1994 the last 2 Corps physicians will have been placed.

Medicaid expansions for children in recent years have been offset by rapidly deteriorating employer coverage of dependents. According to the Urban Institute, between 1984 and 1987, when major Medicaid expansion activities for children were occurring at both the federal and state levels, the total number of children enrolled in Medicaid increased by 600,000 -- from 9.9 million to 10.5 million. However, data from the United States Census Bureau indicate that between 1982 and 1985, the number of children with employer coverage dropped by 1.2 million. For every child added to Medicaid during the mid-1980s, two lost employer coverage.

As it approaches the end of the century, the nation is at a crossroads. We can continue to work year after year for modest and incremental reforms that take us a few steps beyond where we were the year before and improve and strengthen programs, such as Medicaid, that have the potential to do a decent job if further substantial modifications are made. We also can shore up good, but inadequately funded public health service programs so that they can meet at least the same level of need that they met a decade ago when, ironically, health problems looked simpler than they do now. This is essentially the course that many health care advocates both inside and outside Congress have pursued over the past five years, and we can stay on it. It is an honorable course, one that can help many people, and one that may be forced upon us by today's political realities.

But it is not a choice that will fix the fundamental problems plaguing a system that in 1987 spent nearly $500 billion (approximately 11 percent of the GNP) on health care, with gross inefficiency, and yet leaves between 31 and 37 million Americans uninsured and tens of millions more only partially protected or relegated to a public system that is shortchanged and stigmatized because it is perceived as a dumping ground for the poor.

In sorting through the range of more fundamental remedies available to the Commission, the most important task will be ensuring that, the remedies are directly targeted at the problems at hand. Since the two largest groups of uninsured Americans are children and young adults, the Commission's proposals must deal with their needs. Because the needs of children and young adults are those least visible in the political marketplace, the danger is great that they are precisely the ones that may get lost in the shuffle unless special attention is paid.

In 1987, children under age 18 and young adults ages 18 to 24 comprised 37 percent of the U.S. population as a whole. But data from the United States Department of Health and Human Services reveal that they constituted 50 percent of the uninsured population that year. One out of every three young adults was completely uncovered, compared to one in seven adults ages 25 to 54.

These young adults ar[illegible] simply unemployed youth or college students. Included among [illegible]se young adults are more than 10 million young women in their prime childbearing years, as well as millions of young parents of young children many working at first or second jobs. The type of young family most likely to have children is also most likely to have only a full or partial high school education.

The key question is whether a mandated employer benefit law, perhaps the most frequently discussed component of a larger strategy for dealing with the uninsured, will work effectively for these largest segments of the uninsured population. We think not. It is true that the majority of uninsured persons, including children and young adults, are members of working families. However, working families with children, particularly minority and young families, are disproportionately likely to work at low paying jobs that are temporary or part-time in nature or in very and for small firms. They also perhaps are more likely to change jobs with some frequency.

In 1987, one in three of the more than 6 million children living in families headed by a young adult (under age 30) was poor. The near doubling between 1973 and 1987 of poverty rates for children living in young families is directly attributable to the declining earning power of these families. Between 1973 and 1987 the median earnings for all heads of families younger than 30 with children fell by more than 36 percent. By 1987 the median income of young black families was below the federal poverty level for a family of four. Less than 50 percent of all black children living in employed families have employer-provided health insurance, regardless of family [illegible]

A variety of factors have pushed earnings levels downward, including the declining real value of the minimum wage, the growth of part-time and temporary jobs, two-tiered wage structures, and the shift in jobs from the manufacturing to the service sector, each of which has had disproportionate impact or young workers. It it is these young workers with children (both young two-parent families and, increasingly, young, single, never-married mothers) who will most frequently show up in the "excluded pool" of any mandated benefit plan proposal.

Moreover, since young children disproportionately are concentrated in families that are themselves young, it will be the youngest and perhaps the most vulnerable of all poor and minority children who are left out of a mandated benefit proposal. During their most crucial development period, these children thus are the most likely to be not only poor but also uncovered by employer-based insurance.

As young families' ties to full-time, permanent, adequately compensated jobs become more attenuated, so has the likelihood that a mandated employer health benefit system will be a realistic answer for them. As we have seen in the case of mandated benefit legislation now pending in Congress, any effort to enact an employer mandate -- whether a defined benefit or defined contribution -- will necessarily exclude many categories of employees most relevant to the discussion here -- persons working at very low wage jobs, persons working part-time or on a temporary basis, persons working for small firms, and persons employed for less than a certain number of months. This is true not only of young adults and children, but of the third group that is disproportionately uninsured: persons ages 55 to 64. All of this is very logical: the groups worst-served by the existing employer-based voluntary system because of the holes in their work force ties will be the groups worst-served by an employer-based mandatory system once the escape clauses dictated by economic reality and the employers' political power are written in.

The exclusionary nature of an employer mandate in the case of young, minority and low income families with children, is confirmed by recent estimates by Kenneth Thorpe at the Harvard University School of Public Health. Thorpe's numbers show that an employer mandate would still leave uncovered 48 percent of uninsured poor children, nearly 30 percent of uninsured near-poor children (those with family incomes between 100 and 200 percent of the federal poverty level) and 25 percent of children with family incomes over 200 percent of poverty.

This obviously does not mean that the employer mandate is worthless. It does mean that focusing most time, energy and legislative resources on such a mandate runs the risk of replicating what has occurred before: a residual public system, suffering from a lack of time, energy, and money, conceived as an after-though rather than as a primary source of insurance, even though it has millions of beneficiaries. Moreover, it bears all the defects and stigma of a system for the poorest, weakest and least attached to the labor force.

Therefore, in structuring a comprehensive remedy to aid the uninsured, it is essential to bear in mind that the public program -- if a companion to a remedy that builds on employer mandates --will be as important to the currently uninsured populations as the private component. So many currently uninsured children and young adults would be excluded from a mandated private benefit approach that the design of the public component of an overall approach to reducing the number of uninsured must command as much attention from the Commission, and from Congress, as the private component.

Moreover, we believe that ultimately this bifurcated approach is the wrong one and that the basis for an equitable system of health care in the U.S. will not truly be laid until all Americans are insured through a unified public insurance scheme. We recognize that for several reasons mandated employer benefits may be part of the eventual approach to the problem. However, even if such an approach to coverage of uninsured adults is chosen, we strongly urge the Commission to take a different approach to maternity and pediatric coverage and to recommend the establishment of a single universal maternity and pediatric program funded through employer contributions, premiums and general revenues. We recognize that some highly compensated workers will continue to receive enhanced pediatric courage for their dependents as part of their wages and compensation, but this is also true in the case of well compensated workers who receive retiree benefits through the workplace. The presence of a retiree benefit plan for some in no way diminishes the importance of the Medicare program for all.

In formulating a national maternity and pediatric program, we believe that several principles must apply.

1. The program must be universal and not means-tested or residual.

Even if a public companion to a mandated employer program for adults is limited only to adults with family incomes below a certain threshold, we strongly urge that the public maternity and pediatric benefit program be universal and without financially-related eligibility limits. If enrollment is to be highly simplified and the program to have high public acceptance, then all of the current eligibility criteria that currently weigh down the Medicaid program must be removed. If the stigma of being enrolled in a public program is to be eliminated, then it must be a program that is understood to be one that is virtually universal -- like public schools or Medicare or Social Security -- one that the vast majority of families rely on for their maternity coverage and pediatric care.

2. The program must be capable of responding to maternity and pediatric health needs that are not traditionally considered insurable.

Beginning from conception, the vast majority of children have health care needs that are not the traditional focus of insurance plans. With the exception of prepaid health plans, private plans do not routinely fund such coverage as well-child exams, vision, dental and hearing services, and childhood immunizations. Only since 1979 have most employer-provided health insurance plans been required to cover maternity care. Even today, some 5.5 million women of childbearing age whose private insurance is furnished directly or indirectly through employers still are without maternity coverage, either because the employer is small or else because they are minor dependents of insured workers.

At the other end of the spectrum, most insurance plans do a poor job of caring for the very small number of children with disabilities or chronic illnesses severe enough to impair normal daily functioning, whose health care management depends on far more than medical, surgical and laboratory services. Services and equipment that should now be considered absolutely elementary in the care of moderately or severely disabled and chronically ill children are frequently non-existent under conventional insurance. Finally, even insurance plans with relatively good benefits increasingly have costsharing features that effectively nullify the potential value of the covered benefit, particularly in the case of children living in lower-income families.

3. The adequacy of lower-income pregnant women's and children's health care depends not only on having sufficient insurance coverage but also on having access to providers capable of furnishing care geared to these families' special needs.

Without question, children who have insurance receive significantly greater amounts of health care than those who do not. Moreover, the greatest disparities between insured and uninsured children's use of health care occur among children who have one or more chronic illnesses or disabilities and whose need for health care is the greatest.

Most low income families, like all families, understand, appreciate, and make wise use of, the health care system for their children. However, a growing body of evidence suggests that for some low income families, the best outcomes may be achieved when health care is delivered in comprehensive clinical settings that are capable of furnishing care and services far beyond those traditionally found in a physician's office. Most effective have been demonstration programs carried out in clinical settings that involve collaborations between private physicians and publicly funded clinics to ensure that pregnant women and children receive not only good quality medical care but also the full range of ancillary services that these families may need: health and psychosocial counseling; services for children with physical, emotional or developmental delays; services of translators; transportation; assistance in obtaining other benefits such as nutritional and family support services; and advocacy efforts on behalf of children who need services from other systems, such as special education services. When these enhanced services are combined with traditional medical care, the results have been consistently impressive.

Moreover, low income families are disproportionately likely to be truly medically underserved, because they tend to reside in inner cities or rural areas. For these families, even traditional medical care is difficult, if not impossible, to obtain. The vast growth in the supply of physicians has not reached the nation as a whole. Twenty-two states still have areas with no practicing obstetrician/gynecologists. At least 10 of these are states in which at least 50 percent of the population lives in rural areas.

4. Services and benefits should be funded through a mix of adequate third party payment for services rendered adequate direct and prospective grants to selected providers.

In the case of traditionally insurable risks such as physician services for acute and chronic illnesses and conditions and hospital and long term care services, a financing system of direct third party payments to providers for services rendered is acceptable. However, many of the most important services for pregnant women and children may, from a systemic point of view, best be funded through a series of ongoing and prospective grants to primary and specialized providers. This is particularly true for such basic services as preventive dental care and immunizations and specialized services for children with long-term chronic illnesses and disabilities.

The levels at which providers are paid is also a critical issue. In many states the current payment level for obstetrical services under Medicaid is not adequate to cover even a physician's per capita obstetrical malpractice costs or the cost of furnishing care in a comprehensive clinical setting. Reimbursement rates should be set at a level sufficient to cover the cost of providers that serve high risk populations and providers working in severely underserved areas, particularly in rural areas where the number of patients is low and the average per patient cost is thus higher.

With respect to private providers, reimbursement for maternity and pediatric care must be sufficient to eliminate the need for all but modest cost-sharing by families (and non in the case of low-income families). The amounts that families will have to pay for medical care should by and large be calculated into the cost of the premium so that families can manage their health care costs through regular monthly payments. Any deductibles used under the plan should not apply to preventive pediatric services or prenatal care. Costsharing in the case of ambulatory services should be kept nominal, and providers should be prohibited from engaging in balance billing beyond the levels permitted by the plan's costsharing provisions.

5. The universal coverage should be accompanied by a major expansion of programs for developing and delivering comprehensive health and related services in underserved areas.

Even in Canada, where a uniform system of basic national health insurance is in place, provinces supplement third party financing with service delivery programs aimed at risk and underserved families. We therefore recommend major expansion of programs of proven effectiveness, such as community and migrant health centers and the Title V maternal and child health program. We also recommend immediate revival of the National Health Service Corps, with a particular emphasis on recruitment of obstetricians, pediatricians, family practitioners, nurse-midwives and other mid-level professionals.

Chairman ROCKEFELLER. Thank you very much, Ms. Rosenbaum. Steve Monson on behalf of the Consortium for Citizens With Disabilities.

STATEMENT OF STEPHEN MONSON ON BEHALF OF THE CONSORTIUM FOR CITIZENS WITH DISABILITIES [CCD]

Mr. MONSON. Good morning. My name is Stephen Monson and it's a pleasure this morning to have the opportunity to testify in front of this distinguished body on behalf of the Consortium for Citizens With Disabilities. CCD is a working coalition comprised of nearly 60 consumer service providers and professional organizations which advocate on behalf of the 43 million Americans with disabilities.

I have diabetes and I hope my story will serve to exemplify some of the many problems individuals with disabilities continually face. Since my diagnosis 9 years ago I have strived never to let my diabetes get in the way of my goals, accomplishments, or interests. However, like other persons with disabilities, I have encountered unfortunate and frustrating circumstances in which opportunities were lost only because I have a disability.

My discussion on the issue of health insurance and people with disabilities will focus on three areas affecting access: insurability, adequacy, and affordability. Access to health care for individuals with disabilities cannot be considered in a vacuum. The ability to participate fully in the Nation's health care system relates directly to income, employment, and insurability. It is in these areas that persons with disabilities, precisely because of their disability, are frequently at a disadvantage.

As an individual with a disability, I know from personal experience the difficult task families of individuals with disabilities face in the fight to secure health insurance. Most Americans have private health insurance, which is generally associated with employment and higher income levels. I am quite fortunate because I have a job which provides good health insurance.

However, it is startling to realize that nearly three-quarters of the persons with disabilities in this country are unemployed. For these individuals employment-related coverage, unless realized through a spouse or other family member, is not an option. It is virtually impossible to get private health insurance except through employment and even then there are many examples of individuals with diabetes who apply for jobs they are capable of doing, but are then turned down on the basis of their diabetes. This is not only tragic, but discriminatory.

In addition, not everyone who works has access to health care. Many people are self-employed and only eligible for nongroup coverage. Many work part time and therefore do not qualify for health insurance benefits. And others work for small businesses which commonly do not offer employee health insurance. Therefore, affordable private options for the employed uninsured, as for the unemployed, are extremely limited.

This lack of availability for health insurance certainly hits home with me. I've always been entrepreneurial and aspired to become self-employed, perhaps opening up my own business. Like so many other individuals with disabilities, for those individuals with diabetes, no private insurance market exists which is willing to take on the risk of underwriting a policy for an individual. It should not have been surprising to find that no insurance company would accept me and offer an individual policy.

Chairman ROCKEFELLER. Not one.

Mr. MONSON. I looked and looked. There may be a slight, a very small number and very difficult to find. I've been rejected many, many times.

Chairman ROCKEFELLER. In spite of the job, in spite of the income?

Mr. MONSON. The job provides me with health insurance, group health insurance. However, if I want to become insured as an individual that's very, very, very difficult to find. I was rejected based only on the fact that I have diabetes. My job mobility has been my beleaguer. I'm fortunate to be employed, but the threat of losing health insurance when changing employers, essentially holds me hostage to my current job.

Public health insurance does provide some substitution for the lack of private insurance among some people with disabilities, particularly those persons with very low income. CCD supports the concept of universal access to health care and anticipates that this will entail a cooperative public-private response.

CCD recommends that the Commission seek to eliminate discriminatory practices by private health insurance on the basis of disability in efforts to improve access to health care. Furthermore, CCD recommends the 2-year waiting period for Medicare beneficiaries with disabilities be eliminated and that the Commission promote Medicaid reforms which increase provider participation, amend eligibility requirements, and expand services to provide and better meet the health care needs of individuals with disabilities.

I would also quickly like to address health care adequacy for people with disabilities. Over the course of a lifetime people commonly require health and related care for the broad array of services comprising the Nation's health care system. For many people with disabilities difficulties regarding access to care relate not only to a lack of insurance, but also to the problem of underinsurance, particularly as it pertains to long-term and comprehensive care. As an example of this, dramatic brain injury is the leading cause of disability in children and young adults.

Finally, I would like to address the issue of affordability of health care—health insurance for individuals with disabilities. As a group, people with disabilities have lower incomes than the general population. They are three times more likely to have incomes at or near the poverty line. Individuals with disabilities are often subjected to unnecessarily high health insurance costs, arising from faulty perceptions within the health insurance industry that, as a group, they are higher consumers of health care services than those without disabilities.

High private health insurance premiums for persons with disabilities, often as high as 200 percent of the standard cost, represent a substantial barrier to coverage. I would just quickly say that I'm very healthy and extremely conscientious about treating my diabetes and managing my condition for my long-term health and well-being. I do not have health care bills any higher than my peers who do not have chronic health conditions and I'm confident that my preventive efforts will keep my health care costs low in the future.

I hope that CCD and the Commission will work together to improve methods and find ways of better identifying risk so that all individuals, including those with disabilities, can pay health insurance premiums that accurately reflect their personal status. And CCD urges that the Commission's recommendations for improving access to health care, including long-term care, take into consideration the limited availability of individual and family financial resources. Thank you.

[The prepared oral statement of Mr. Monson follows:]

[The prepared written statement of the Consortium of Citizens With Disabilities appears in the Appendix, p. 542.]

Consortium for
Citizens with
Disabilities

ORAL TESTIMONY - PEPPER COMMISSION

My name is Stephen Monson and it is a particular pleasure this morning to have the opportunity to testify in front of this distinguished body on behalf of the Consortium for Citizens with Disabilities (CCD). CCD appreciates the opportunity to provide members of the Pepper Commission with information and recommendations regarding access to health care, including long-term care, for the nation's 43 million Americans with disabilities.

CCD is a working coalition comprised of nearly 60 consumer, service providers, and professional organizations which advocate on behalf of persons with disabilities. CCD believes that people with disabilities should have full access to appropriate, adequate, and affordable health care and related services.

My testimony today contains several general recommendations. However, CCD will submit a list of specific recommendations with its written testimony.

I have diabetes and I hope my story will serve to exemplify some of the many problems individuals with disabilities continually face. Since my diagnosis 9 years ago, I have never let diabetes get in the way of my goals, accomplishments, or interests. However, like other persons with disabilities, I have encountered unfortunate and frustrating circumstances in which opportunities were lost only because I have a disability.

My discussion on the issue of health insurance and people with disabilities will focus on three areas affecting access: insurability, adequacy, and affordability. Health insurance can be viewed as the ticket for admission to the nation's health-care system.

Access to health care for individuals with disabilities cannot be considered in a vacuum. The ability to participate fully in the nation's health-care system relates directly to income, employment, and insurability. It is in these areas that persons with disabilities, precisely because of their disabilities, are frequently at a disadvantage.

As an individual with a disability, I know from personal experience the difficult task families of individuals with disabilities face in the fight to secure health insurance. An individual's access to health care is often contingent upon another family member's employment, earnings, insurance coverage or other factors. At 6 months my daughter was diagnosed with a seizure disorder. I can only hope that she will not face the discrimination I and other persons with disabilities have faced and that throughout her life, she has access to adequate and affordable health care.

Most Americans have private health insurance which is generally associated with employment and higher income levels. I am quite fortunate because I have a job which provides health insurance. However, it is startling to note that nearly three-quarters of the persons with disabilities in this country are unemployed. For these individuals, employment-related coverage, unless realized through a spouse or other family member, is not an option. It is virtually impossible to get private health insurance except through employment. And even then, there are many examples of individuals with diabetes who apply for a job but are turned down on the basis of their diabetes. This is not only tragic but discriminatory.

In addition, not everyone who works has access to health insurance. Many people are self-employed and only eligible for non-group coverage; many work part-time and therefore, do not qualify for health insurance benefits; and others work for small businesses, which commonly do not offer employee health insurance. Therefore, affordable private options for the employed uninsured as for the unemployed are extremely limited.

This lack of availability for health insurance certainly hits home with me. I have always been entrepreneurial and aspired to become self-employed -- perhaps even opening up my own business. Like so many individuals with disabilities, for individuals with diabetes, no private insurance market exists which is willing to take on the risk of underwriting a policy for an individual. It should not have been surprising to find that no insurance company would accept me and offer me an individual policy. I was rejected based only on the fact that I have diabetes. Job mobility has been my beleagurer. I am fortunate to be employed; but, the threat of losing health insurance when changing employers essentially holds me hostage in my present job.

Public health insurance does provide some substitution for the lack of private insurance among some people with disabilities, particularly those persons with very low incomes. Approximately 3 million people qualify for Medicare benefits on the basis of disability. Medicaid offers health-care benefits to approximately 25 million low-income Americans, many of whom are elderly, blind, or have other disabilities. However, this still leaves large gaps in the number of individuals covered, in addition to the range of health-services provided.

CCD supports the concept of universal access to health care and anticipates that this will entail a cooperative public-private response. CCD recommends that the Commission seek to eliminate discriminatory practices by private health insurers on the basis of disability in its efforts to improve access to health care. Furthermore, CCD recommends that the 2-year waiting period for Medicare beneficiaries with disabilities be eliminated and that the Commission promote Medicaid reforms which increase provider participation, amend eligibility requirements, and expand services to better meet the health-care needs of individuals with disabilities.

I would also like to address health-care adequacy and people with disabilities. Over the course of a lifetime, people commonly require health and related care from the broad array of services comprising the nation's health-care system. For many people with disabilities, difficulties regarding access to care relate not only to a lack of insurance but also to the problem of underinsurance, particularly as it pertains to long-term and comprehensive care.

As an example, traumatic brain injury is the leading cause of disability in children and young adults. People with head injuries often require intensive emergency treatment, comprehensive acute care, rehabilitation, and long-term care, and ongoing support services. A survivor of a severe brain injury typically faces 5 to 10 years of intensive services at an estimated cost in excess of $4 million. Limits on these services jeopardize full recovery and opportunities to lead independent lives in the mainstream of society.

CCD is particularly concerned that the Commission consider the long-term care needs of both children and adults with disabilities and chronic illnesses in crafting solutions to long-term care access problems.

CCD urges the Commission to include in its recommendations to Congress mechanisms which will enhance access to comprehensive care and long-term care and related services for people of all ages with disabilities, including developmental disabilities and chronic illnesses.

Finally, I would like to address the issue of affordability of health insurance for individuals with disabilities. As a group, people with disabilities have lower incomes than the general population. They are three times more likely to have incomes at or near the poverty line. Individuals with disabilities are often subjected to unnecessarily high health insurance costs arising from faulty perceptions within the health insurance industry that, as a group, they are higher consumers of health-care services than those without disabilities. High private health insurance premiums for persons with disabilities, often as high as 200 percent of the standard cost, represent a substantial barrier to coverage.

I am very healthy and am extremely conscientious in treating my diabetes and managing my condition for my long-term health and well-being. I do not have health-care bills any higher than my peers without chronic health conditions and I am confident that my prevention efforts will keep my health-care costs low in the future.

CCD believes that improved methods are needed to better identify risk, so that all individuals including those with disabilities can pay health insurance premiums that accurately reflect their personal health status. CCD urges that the Commission's recommendations for improving access to health care including long-term care take into consideration the limited availability of individual and family financial resources.

If time had permitted, I would have addressed the issue of supply of health-care personnel and the need for data on health-care needs and patterns of utilization of health care for people with disabilities. Our written testimony will provide specific details in these areas.

It has been a pleasure to testify in front of you today. CCD believes it is little to ask that every American have an equal opportunity for access to health care. Undeniably, it is a difficult task. However, access to health care should be a right; and in the spirit of our democratic tradition, this nation has an obligation to make sure every American has adequate access to affordable, quality health care.

Chairman ROCKEFELLER. Thank you, Mr. Monson, very much. Could you furnish me, incidentally, with a breakdown—when you say nearly three-quarters of persons with disabilities are unemployed—a breakdown in the disabled group. Which are the disabilities which fit into those three-quarters who are unemployed? Do you understand my question?

Mr. MONSON. Yes.

Chairman ROCKEFELLER. I don't mean now, but just for the record.

Mr. MONSON. I couldn't tell you.

Chairman ROCKEFELLER. But can you find out?

Mr. MONSON. Certainly. I'm sure that I can provide it.

Chairman ROCKEFELLER. It would be very helpful to me.

[The information referred to appears in the Appendix, p. 600.]

Chairman ROCKEFELLER. Eric Schulman, director of legislation for the National Council of Senior Citizens.

STATEMENT OF ERIC SCHULMAN, DIRECTOR OF LEGISLATION, NATIONAL COUNCIL OF SENIOR CITIZENS [NCSC]

Mr. SCHULMAN. Thank you, Mr. Chairman. It would not be understating the enormity of America's health care crisis to suggest that our system, such as it is, is in disarray. The costs being borne by consumers, industry, and Government are breaking our backs. Since 1980 national spending for health care services has more than doubled, from $240 billion to over $500 billion a year and it continues to increase at the alarming rate of over $50 billion a year.

Of that $500 billion, consumers are paying one-fourth out of their own pockets. Health care costs are out of control and we are all feeling the pinch. Over 40 million Americans have no health insurance. Workers are giving up more and more of their paychecks to pay for health care. The elderly are seeing their out-of-pocket costs skyrocket. American industrial giants in the auto, steel, and communications industry are waking up to the impact of rising health care costs on their bottomline.

Yet, for all our awareness of the growing dimension of the problem, our solutions have been so limited in scope that they have done little more than put Band-Aids over the wounds. The evidence is unassailable. Piecemeal reform does not work. Our health care system is like a balloon. Squeeze in one place, it will expand someplace else.

We pass a Hospital Reimbursement Program and physician costs go through the roof. Now, Congress is considering Medicare limits of physicians costs, something which we strongly support, but no doubt doctors will figure out a way around it. Witness the response of physicians to the recent Medicare reimbursement reductions. They simply increased the number of visits and tests to maintain their income levels. Doctors can "game" the system with the best of them.

The National Council of Senior Citizens and its members are convinced that fundamental systemic reform of the way we provide health care in the United States is essential and that we must begin the process now. We must burst the health care balloon and put in its place a more equitable, more efficient, and more affordable national health care program. As you have no doubt heard many times, we along with South Africa are the only nations of the western industrialized world that have not adopted some form of national health program. Yet, such a program can insure that all Americans have access to decent quality, affordable health care. What are we waiting for?

Polls show that many Americans favor the Canadian model for a national program. This model, while not perfect, has many aspects worth looking at. The costs are much lower than ours and everyone is given health care regardless of his or her ability to pay. In the United States, money determines access and drives the system. Costs in Canada are kept down by the national government controlling how much doctors can charge and hospitals can spend. Standards are kept high by the Federal Ministry of Health and local governments, which oversee day-to-day operations.

Unfortunately, efforts to move toward a national health care system continue to be blocked by most medical groups, and particularly the American Medical Association. The AMA, which opposed the passage of Medicare, says that any changes to a more equitable system would result in poor care and rationed medicine. But health care is already rationed in this country. If you cannot afford insurance or your insurance doesn't cover a particular procedure, then the odds are you aren't going to get the care you need. If access to health care is to be rationed, then it should be rationed on the basis of health care need and not on the ability to pay.

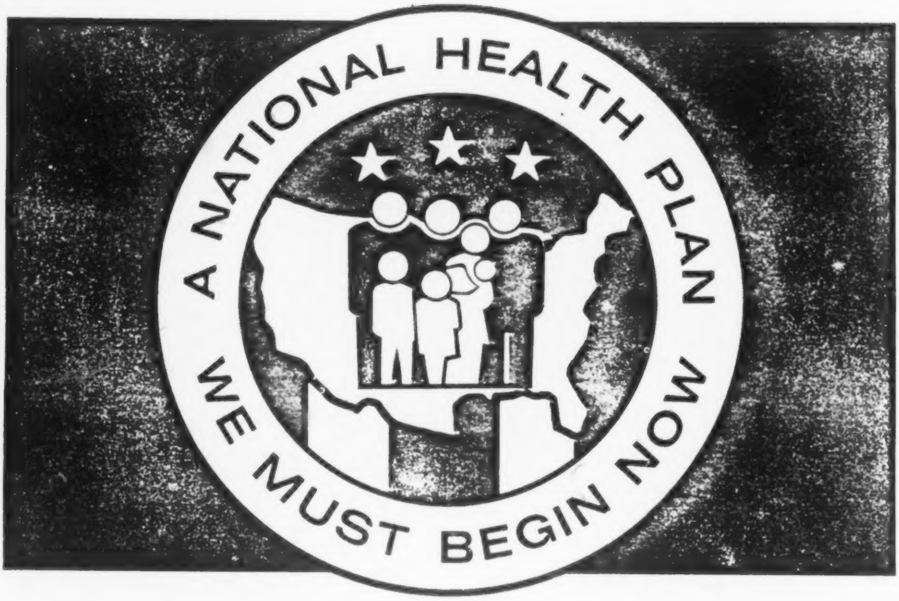
Mr. Chairman, you and other members of the Commission may have wondered why NCSC is testifying today on the issue of universal access, rather than earlier on the issue of long-term care. The answer is quite simple. While NCSC feels that long-term care is a much-needed benefit for many older Americans and younger Americans as well, such a program must be considered in the context of an overall health care reform package. I might add that this Commission is in the historically unique position to produce just such a plan, since your mandate is to address both the long-term care and access needs of our Nation.

NCSC wants universal health care for our grandmothers and grandfathers who may need to enter a nursing home. We want it for our fathers and mothers struggling through a devastating illness. We want it for our disabled brothers and sisters who need long-term care. We want it for our sons and daughters so they need not worry about the high cost of health insurance as they move away from their homes for the first time. And most of all, Mr. Chairman, we want it for our grandsons and granddaughters. We want them born healthy so they can live the full lives their parents and grandparents envisioned for them.

Mr. Chairman, national health care is needed now; the time is right. A large majority of Americans support the change. Polls show that a majority of physicians actually support national health care. And even corporate America is showing signs of support. This country should not allow another child to die because the parents do not have the money to buy insurance. Another pregnant woman should not be turned away from an emergency room because that hospital doesn't accept Medicaid patients. Another senior citizen should not be forced into impoverishment because he or she needs constant chronic care. And most of all, Mr. Chairman, sick people shouldn't have to wait until they're forced into an emergency room to receive the care they need. Preventive care saves both lives and money.

As you have all seen, the political will exists outside of Washington to establish a national health program. We must begin now. Thank you.

[The prepared statement of Mr. Schulman follows:]


A NATIONAL HEALTH PLAN
WE MUST BEGIN NOW

Universal Access to Health Care

Statement by

Eric Shulman
Director of Legislation

Before the
Pepper Commission
U.S. Bipartisan Commission on Comprehensive Health Care

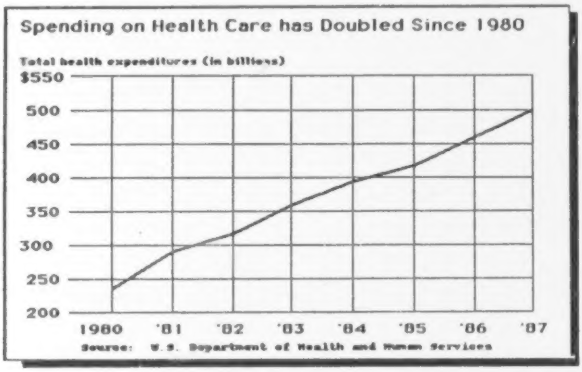
October 24, 1989
Washington, D.C.

NATIONAL COUNCIL OF SENIOR CITIZENS
NCSC

Mr. Chairman, Commissioners, thank you very much for allowing us to testify before you today. I'm Eric Shulman, Legislative Director of the National Council of Senior Citizens.

It would not be understating the enormity of America's health care crisis to suggest that our "system," such as it is, is in disarray. The costs being borne by consumers, industry and government are breaking our backs.

Since 1980, national spending for health care services has doubled--from $240 billion to over $500 billion a year. Of that $500 billion, consumers are paying one-fourth out of their own pockets.


Spending on Health Care has Doubled Since 1980

Source: U.S. Department of Health and Human Services

Health care costs are out of control and we are all feeling the pinch.

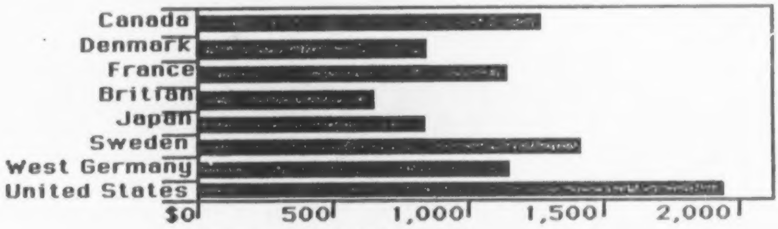
Over 50 million Americans are either uninsured or under insured. Workers are seeing more and more of their paychecks going to pay for health care. The elderly are seeing their out-of-pocket payments skyrocket. In fact, seniors are paying the same percentage of their total health care costs as they did before the passage of Medicare. Medicare is simply filling the same gap that was filled by private insurance for those who had it, back in 1965. With medical inflation, however, older Americans are paying a larger portion of their income for health care. In 1980, seniors paid 13 percent of their income on health care; in 1988, they paid 18 percent. American industrial giants in the auto, steel, and communications industry are waking up to the impact of rising health care costs on their bottom line. Yet, for all our awareness of the growing dimension of the problem, our solutions have been so limited in scope they do little more than put "band-aids" over hemorrhaging wounds.

The evidence is unassailable--piecemeal reform does not work. Our health care system is like a balloon, squeeze in one place and it will expand some place else. We pass a hospital prospective reimbursement program and physician costs go through the roof. Now Congress is considering Medicare limits on physicians' costs--something which we strongly support since Medicare costs alone have risen more than 14 percent annually in eight out of the last nine years--but, no doubt, doctors will figure a way around it. Witness the response of physicians to the recent Medicare reimbursement reductions--they simply increased the numbers of visits and tests to maintain their income levels. Every day laboratories perform 40 million tests. That's enough tests to provide every American with one test every six days. Doctors can "game" the system with the best of them.

Even more disturbing is our high rate of infant mortality. In any study, the United States consistently falls beneath all other industrialized nations. This decay is even more prevalent for non-whites. A black baby born in Detroit has a smaller chance of surviving its first year than a baby born in Costa Rica. Americans should be ashamed and angry about this, and they are. In Canada, 98 percent of women receive prenatal care. Only 75 percent of American women ever do. This also drives up our medical inflation. Premature and sick babies cost thousands of dollars a day. Yet many of these babies' problems could have been prevented with adequate prenatal care. All while 300,000 hospitals beds a day go unfilled. Fortunately, expanded Medicaid coverage for pregnant women and infants was one of the apparent survivors in the Catastrophic crash.

Other industrialized nations have higher life expectancies and lower infant mortality rates, even as they spend less money on a per-capita basis. Americans spend about $2,000 a year medical costs, while Europeans spend only about $1,000 to $1,200 a year. This is especially true since other countries are able to contain costs and aren't suffering the 15 to 20 percent medical inflation a year like the United States. Also, in the U.S, 23 percent of our health costs go to administration, in Canada, 13 percent. Mr. Chairman, if all we did was to lower our administrative costs to 13 percent, we would save, as a nation, about $50 billion a year; enough money to provide health insurance for every American

Per Capita Health Expenditures - 1984

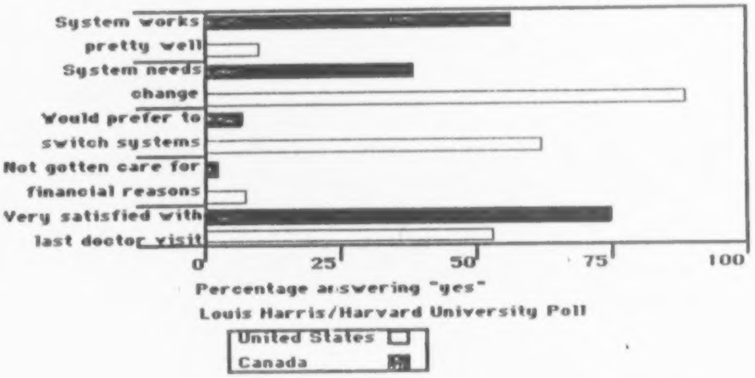


Source: Washington Post

currently without it. Plus, hospital administrators are increasing four times faster than physicians. Clearly, the United States is paying more, and getting less.

The National Council of Senior Citizens and its members are convinced that fundamental, systemic reform of the way we provide health care in the U.S. is essential and that we must begin the process now. We must burst the health care balloon and put in its place a more equitable, more efficient and more affordable national health care program. As you have no doubt heard many times, we along with South Africa are the only two nations of the western industrialized world that have not adopted some form of national health program. Yet, such a program can ensure that all Americans have access to decent quality, affordable health care. What are we waiting for?

Consumer Satisfaction



Louis Harris/Harvard University Poll

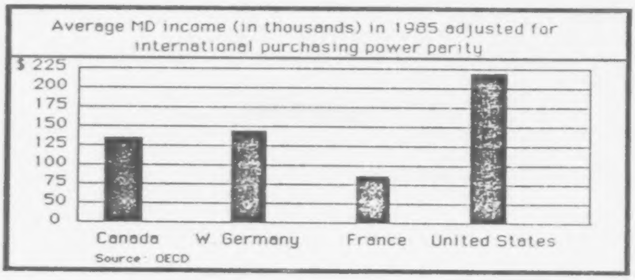
Polls show that 61 percent of Americans favor the Canadian model for a National Health Care System. This model, while not perfect, is extremely popular among Canadian citizens--only three percent of Canadians say they would return to a U.S.-style system. Eighty-nine percent of Americans say our health care system needs fundamental change or complete rebuilding.

The cost of health care in Canada is much lower than in the U.S., with Canadians paying only 8.6 percent of G.N.P., while the U.S. pays 11 percent.

Many critics of a proposed American national health care system raise the specter of "rationing." Yet, we in the U.S. ration care as much as they do in Canada. Theirs is a rationing system based on need, ours is one based on wealth. Even for those lucky enough to be covered by one of the nation's 1,500 health insurance programs, health care is rationed, with large, profit-minded companies deciding what care is to be provided and what care people can do without. Even if coverage is provided, many companies still require patients to pay a great deal of costs out of their own pocket.

In Canada, everyone is given health care regardless of his or her ability to pay. Costs are kept down by the national government controlling how much doctors can charge and hospitals

Average MD income (in thousands) in 1985 adjusted for international purchasing power parity



Source: OECD

can spend. Standards are kept high by the Federal Ministry of Health and local governments which oversee day-to-day operations. Plus, patients are still free to choose their physicians and doctors are privately employed. And Canadian physicians are still well-paid, earning five times what an industrial worker makes.

One argument often levelled against the Canadian system is that it limits access to exotic medicine and non-emergency surgery. Let's face it: high-tech medicine is expensive. Yet, in the U.S., hospitals and clinics routinely buy CT scanners, MRIs and other extremely expensive medical equipment. Such equipment is either under utilized or used unnecessarily (i.e., using an MRI scan for a broken bone). These unnecessary costs then continue to fuel the fires of medical inflation.

The Swedes have solved the exotic technology problem without undue hardship by establishing six high-tech regional centers (one center for about every million and a quarter people). Problems that cannot be handled at a local level are referred to these centers. Indeed, this is how some planning problems are handled in the U.S. with some facilities concentrating on burn victims, others on heart attacks, cancer, or stroke for example. Clearly, we should examine all of our options before choosing what is right for us. But I do not, and cannot, believe that we cannot solve this problem.

Unfortunately, efforts to move toward a national health care system continue to be blocked by most medical groups, particularly by the powerful American Medical Association which gave over $3 million to political candidates in the last election. The AMA, which opposed the passage of Medicare, and now pays for full-page ads in major newspapers claiming their support, says that any changes to a more equitable system would result in poorer care and rationed medicine. But health care is already rationed in this country. If you cannot afford insurance or your insurance doesn't cover a particular procedure, then the odds are you aren't going to receive the care you need. If, as we have said, access to health care is to be rationed, it should be rationed on the basis of need, not on the ability to pay.

Mr. Chairman, you and other members of the Commission may have wondered why the National Council is testifying before you today on providing universal access rather than at the long-term care hearing held a couple of weeks ago. The answer is quite simple. While NCSC feels that long-term care is an essential need for many older people--and young people as well--we have learned a painful lesson about piecemeal reform in the Catastrophic Health Insurance saga. We must adopt a long-term care program, but it should be as a part of an overall national health care program.

NCSC wants universal health care for our grandmothers and grandfathers who may need to enter a nursing home. We want it for our fathers and mothers struggling through a devastating illness. We want it for our disabled brothers and sisters who need long-term care. We want it for our sons and daughters so they don't need to worry about the high cost of health insurance as they move away from home for the first time. And most of all, Mr. Chairman, we want for our grandsons and granddaughters. We want them born healthy so that they can live the lives their parents and grandparents envision for them.

Mr. Chairman, the inevitable force of change is coming. Over the past several months, the Pepper Commission has held hearings across this country and has heard and seen thousands of our members fighting for a national health care system. Just as the campaign for Medicare began after a long period of neglect for the health of our people, the time for America to enact a universal, comprehensive national health care program may be in sight. The NCSC Executive Board has adopted the following ten-point program in order to establish a basic set of principles for developing national health care legislation. We offer these principles to the Commission and we urge you to consider them carefully as you move forward in your recommendations.

1) Universal Access

Under the program, every American will be covered, regardless of ability to pay. Basic health protection must be considered a right and the program must clearly establish this principle.

2) Comprehensive Benefits

In addition to protection for hospitalization and physician services, the program must cover all medically necessary health and preventive services, long-term institutional and home health care, and other essential health services.

3) Financing

Any system of financing a new national health care program must be broad-based and progressive, based upon our nation's traditional approach to financing social insurance programs.

4) Cost-sharing

Cost-sharing requirements on beneficiaries must not create economic barriers to receiving adequate health care. Deductibles and co-payments penalize the sick and therefore should not be relied upon as sources of financial support for the program. All physicians would be required to accept assignment and would not be allowed to pass along additional fees to beneficiaries.

5) Quality Assurance

Standards would be established to govern patient care in all medical settings. Independent oversight of the medical profession and peer-review organizations would monitor the quality of all medical care. Physicians, nurses and other health care professionals who have demonstrated a commitment to providing the highest quality care should be recognized and rewarded.

6) Cost-containment

A system of budgeting for all health care services would be established and adhered to in determining payment policies to service providers. Prospective hospital budgeting and a national physicians' fee schedule coupled with expenditure targets and negotiated on an annual basis will act to control health care costs.

7) Health Planning

Resources for capital expenditures on new construction and rehabilitation of existing facilities would be allocated on the basis of local, state and regional needs for additional health care services. This will ensure that the health care needs of all our citizens will be considered in determining spending patterns for the new technologies and services.

8) Patients' Rights

Patients must be treated in a timely manner and with compassion and decency and a patient-grievance procedure must be established. The burden of seeking reimbursement for services rendered should fall on the health provider and not the patient.

9) Program Administration

The national health program will be administered in such a way as to assure a strong role for the Federal government and the states. In addition, health care consumers must have the right to participate in the administrative and policy-making decisions at all levels of government.

10) Role of Private Insurance Carriers

The role of private insurance in a national health program will have to be carefully scrutinized. Insurance carriers will only be allowed to participate in the program if they meet minimum established standards for cost-effective administration and responsiveness to consumer needs. This will be essential to keeping overall program costs down, since insurance company profits and high administrative costs contribute greatly to runaway health cost.

National health care is needed now. The time is right. A large majority of Americans support such a program. Polls show that a majority of physicians actually support national health care and corporate America is showing increasing signs of support. This country should not allow another child to die because the parents do not have the money to buy insurance, another pregnant woman should not be turned away from an emergency room because that hospital doesn't accept Medicaid patients. Another senior citizen must not be forced to impoverish herself or himself because of a need for constant care. And most of all, Mr. Chairman, sick people should not have to wait until they're forced into an emergency room to receive the care they need. Preventive care saves lives and money. As you have all seen, the political will exists outside of Washington to establish a national health care program. How long do we have to wait for it?

Chairman **Rockefeller**. Thank you very much. Has Arthur Flemming arrived? Not yet, OK. Are there questions for the panel?

Representative **Stokes**. Mr. Chairman.

Chairman **Rockefeller**. Congressman Stokes.

Representative **Stokes**. Thank you, Mr. Chairman. Mr. Glasser, in your testimony you point out the fact that our health care system is discriminatory against blacks and other minorities. I think this has been fairly well documented, particularly through the Secretary's task force report in 1985, which pointed up the wide disparity between black and white health status in America. Can you tell us precisely how your legislation remedies this problem?

Mr. **Glasser**. There are several ways, Mr. Stokes. Our legislation, in the first place, abolishes Medicaid. Medicaid is, in our view, a separate but less equal system of health care. Less than half the people eligible for Medicaid can get on it and the numbers I cited about State eligibility are just one proof.

The first thing you need to do is get people into a system that has uniform access to care. That is not true for blacks and minorities. The majority of blacks and minorities cannot get health insurance. The death rates and the illness rates for blacks and minorities in this country run about twice for the major illnesses, about twice those of whites. I believe that's a discriminatory system. I believe that's a way of assuring that minorities will continue to get less adequate care.

This is a system which, incidentally, has seen a retrogression, a decline in the infant mortality reductions for black and minority children. In other words, while the rest of the Nation was slowly improving, the black and minority children in the last 2 years are slowly declining in their ability to reduce death rates. When you have inadequate care, when you have inability to get insurance, when you have low-income people, you have, sir, foredoomed those that you're trying to protect.

Representative **Stokes**. I agree with all of that, but I'm trying to see precisely how your legislation cures the problem.

Mr. **Glasser**. The legislation cures the problem in a very simple way. It states equal access to universal care with comprehensive benefits is assured to all Americans. They either get it through the insurance system, which has certain restrictions on it, or they get it through the State counterparts to the insurance system, and which are available for those who are not able to get insurance. Their getting that is assured by the State program, it is assured with no payments by people who are at or below the poverty level, by no payments for women, pregnant women, and infants who are at 150 percent or less of the poverty level, so that we start out at a level playing field, which we do not now have.

Representative **Stokes**. Thank you, Mr. Chairman.

Chairman **Rockefeller**. Senator Durenberger.

Senator **Durenberger**. I want to direct either a question or an observation both at the Chair and my colleagues and to Mr. Monson. I guess in the area that we're addressing here, I haven't noticed a whole lot of attention being paid to the large number of Americans with disabilities. I must say that we've spent a whole lot of time in other places dealing with the Americans With Disabilities Act and this major piece of civil rights legislation, if you will, for Americans with disabilities. But when it comes to health insurance, everybody seems to be ducking the issue.

It seems to me that if, in fact, we're going to do comprehensive health care, we're going to have to recognize, as members of this Commission who have bills have recognized, that the best place to buy it is in the workplace. But right now it's like two-thirds of Americans with disabilities don't have a work connection, even though most of them are capable of it, they don't have a work connection.

So, the workplace is, in effect, holding these people off from the opportunity to buy what all the rest of us who don't have—allegedly don't have disabilities can get at, which is health insurance. And even if you were there, particularly if you were in a small business, if like you, you have diabetes or some other preexisting condition the tool that the workplace uses to provide health insurance, that is, health insurance, discriminates almost knee-jerk automatic. You've got diabetes, that's a preexisting condition, we don't want to touch you. The smaller the group, the less likely they are to touch you.

If, in fact, I've touched on a real serious problem—I mean, there are a couple of ways to do that. We can take everybody who has a defined disability and put them over here and we're going to treat all of you folks differently over here. We're going to send you to certain docs, we're going to send you to certain hospitals, we're going to call you long-term care folks, we're going to put you in State risk pools, or whatever, to protect the other folks against the consequences. It seems to me we're going to miss out on an opportunity to make some money off of people with disabilities, because they don't have to be sick all the time, you know, they don't have to be a source of great cost concern to employers or the insurance system.

You've promised us some specific recommendations, I think.

Mr. MONSON. Yes; we have some——

Senator DURENBERGER. Is it possible——

Mr. MONSON [continuing]. Written testimony that goes into specifics. I just didn't have time to discuss that.

Senator DURENBERGER. Well, I'm sharing sort of a frustration, Mr. Chairman, with the fact that I think this is an area that is incredibly costly, if you will, to the kind of system we run today, but it doesn't have to be that costly. And I think we're going to need a fair amount of help as we go about debating our recommendation as to what to do about this particular area.

Mr. MONSON. I might just add that I'm willing to pay for health insurance if I could find access to good health insurance. And in some cases I found companies that push you into a category of inferior health insurance for diabetics. You know, oh, yes, we take diabetics they say. But then when you examine the quality of the coverage, it's very poor and it's very expensive. I would like to have the premium coverage and I would be willing to pay my fair share. But it's not accessible.

Representative STARK. Would the distinguished Senator yield?

Senator DURENBERGER. Of course.

Representative **Stark**. Just to follow up on Mr. Monson. Have you had any experience with the 19 States or so that have risk pool programs?

Mr. **Monson**. Risk pool?

Representative **Stark**. Are you familiar with that? Connecticut, Wisconsin, I can't think of all the other States, but I believe there are about 19, where the State provides a risk pool and you can buy private insurance for a price, I think, not to exceed 110 or 120 or 150 percent of regular insurance. People with epilepsy, diabetes, or other preexisting conditions, can get insurance through the pool. Now, I don't know whether you're familiar with those programs and how well they work.

Mr. **Monson**. I'm not specifically, but in my State of Virginia I know the State has done something to try to make it accessible for diabetics. However, as I just mentioned, when I really checked into the specifics it wasn't very quality care.

Mr. **Glasser**. Mr. Chairman, may I comment on the discussion here? The question of insurability of the disabled has gotten increasingly worse over the last 25 years that I have dealt with the subject. It has become worse because the insurance system, in their efforts to secure reductions or maintain lower costs, have eliminated more and more of the disabled through a system of barring those with preexisting conditions, other restrictions, which have eliminated most of the disabled.

There are two ways in which this can be remedied, Senator Durenberger. One is through the existence of State requirements that bar preexisting conditions qualifications as a condition of insurance. In other words, if you have a condition you're eligible like everybody else who works for an employer.

Part of that I would say to you, sir, in your query about State risk pools, our uniform experience across the Nation is they have all practically failed. The have failed because in order to keep them going they have had to increase their premium rates to the point where they are prohibitive for the disabled or they have required State subsidies of this small group, proportionately, to the extent that States have been unwilling to continue those subsidies. I believe, in the opinion of most of us, the State risk pools don't work and they have largely been eliminated.

Finally, you have had this morning before this Commission and you've had other submissions to indicate there is a simple way of getting rid of the business of discrimination against the disabled. And that is it's called universal access to a decent set of benefits without regard to individual eligibility.

Chairman **Rockefeller**. Further questions?

Commissioner **Davis**. Mr. Chairman, may I ask a question of Ms. Rosenbaum from Children's Defense Fund?

Chairman **Rockefeller**. Yes.

Commissioner **Davis**. Ms. Rosenbaum, I enjoyed your testimony very much. One of your points was that even those who might have sufficient coverage have difficulty at times finding providers of care. And at least in your text you used the example of obstetricians, gynecologists. Would you not agree that this is a dual problem here or maybe primarily a problem of professional liability and malpractice that makes obstetrical care not available to people?

Certainly in my State of North Carolina out of 100 counties we have 20 in which we have lost obstetrical care, not because the providers are not there and wanted to do it, but because of the threat of the professional liabilities of malpractice problem and this is still another problem that impacts on proper care for children. Would you agree with that?

Ms. ROSENBAUM. Absolutely, Dr. Davis. The recently issued report by the Institute of Medicine on the impact of malpractice liability on obstetrics certainly illustrates what rising health care practice costs have done in the area of obstetrics. I might add that it's not only in rural areas and not only a matter of cost. In many areas of the country malpractice insurance is unavailable at any price to family practice physicians who are the primary source of obstetrical care in rural areas.

I would note, however, that years ago when malpractice liability costs were much lower, relatively speaking, than they are now, there was and continues to be a severe problem with access to medical care for lower income families either because they are geographically isolated from physicians, or because their care is sometimes more complicated and their care needs go beyond services that many obstetricians in private practice alone are able to provide. I think the recent report from the Department of Health and Human Services on the content of maternity care underscores the fact that maternity care goes beyond medical care. And so, what we're seeing today is the same low access rates applied to a shrinking pool of obstetrical providers and it's made the problem that much worse.

Commissioner DAVIS. Thank you, ma'am.

Chairman ROCKEFELLER. Yes, Jim.

Commissioner BALOG. This gets down to the question of making choices because of resource limitations and Mr. Schulman, in particular, helped me phrase my question. And that is, if we have to make a choice between long-term care issues that we're discussing and access, I gathered from your testimony that you would opt for the access, solve the access question. In particular, you referred to the Canadian model and the Canadian model has no long-term care in it. So, I thought perhaps you were aiming in that direction. Am I correct about that?

Mr. SCHULMAN. Not quite. We do believe and certainly our membership would attest to the importance of long-term care protection, but we believe that it ought to be in the context of the development of a universal health program. We may not necessarily be able to implement a comprehensive chronic care program overnight. In all likelihood we won't be able to do that. I do think that this country will have to come to grips with the issue that we cannot assume that the private sector will solve the problem and that such a program needs to be a part of a national program, perhaps phased in over a period of time.

Chairman ROCKEFELLER. To follow up on that. If, let's say, there's a union worker that has the good health plan and he's at the high end of that or she's at the high end of that, being relatively lower risk, what is it that gives you confidence, Mr. Schulman, or anybody else, that that particular worker would be willing to look at a universal program which might then make it more difficult for them to be at the high end, so to speak, of the coverage?

Mr. GLASSER. Mr. Chairman, I'd like to answer that since we have about a dozen major national unions which are part of our coalition and whose presidents are on our board. I'd like to answer that by saying, the major development of support for universal health care in the last 20 years has been the union movement. That those workers who are well protected are sufficiently aware of the price they paid in collective bargaining to get those benefits. That they are deeply concerned about the escalating costs without controls that are characteristic of America's health care system today. That we have at the moment at least two international union strikes in the telephone industry and one in the coal mining industry that are entirely on the issue of management attempting to shift the costs of health care premiums onto the backs of workers.

I would say to you, sir, today that the union movement is very strongly for universal health care and those who are best protected are in the lead of those wishing for reform and controls.

Chairman ROCKEFELLER. I note your degree of satisfaction. Sometimes there's a difference, you know, between union leadership and union membership on subjects and I still retain my question. And that is, do you think—and I don't necessarily refer to a union worker, but somebody that has good coverage, high end coverage—would favor, let's say, a national health plan where the higher cost presumably would either increase his costs or reduce his benefits regardless of whether a particular union had a position on it?

Mr. GLASSER. Well, in the first place, a particular union that takes a position that doesn't reflect the membership through the democratic process, somehow loses the leadership. The leadership of a union has to begin to reflect what its members wish or it doesn't have a membership.

Chairman ROCKEFELLER. Mr. Glasser, I'm aware of that. I really don't want to discuss democracy this morning. I was just trying to ask a question of you. If you could answer the question or, Mr. Schulman, if you could answer the question.

Mr. GLASSER. Well, the question is, do those who have higher protection, regardless of whether they're union people, wish to see that protection continued? Is that the question?

Chairman ROCKEFELLER. No; the question would be, if there were a national plan, thereby costing more, with more participating, would there not be the thought on the part of those at the high end of coverage that their high end may be reduced or may be increased in cost or whatever?

Mr. GLASSER. When you have an opportunity, sir, to look at the plan that we have developed, the Health Security Partnership, I believe you will see that the assumption that the costs continue to increase with increased participation is not correct. That, in fact, the costs are far more contained than they are in the present system. Therefore, the cost to all participants proportionately do not increase as much. It is therefore in the interest of the non-union as well as of the union worker, if you wish to make that distinction, to be part of a system where everybody is in and where the whole system is able to restrain costs.

Chairman ROCKEFELLER. Mr. Schulman.

Mr. SCHULMAN. I would only add this, Mr. Chairman. I would say, yes, there will be people who have comprehensive health programs now and Cadillac benefits who probably will be resistant to this type of change. After all, they have a vested interest in preserving the status quo which serves them quite well. I would not, therefore, suggest that we would have 100 percent unanimity of support for this type of a program. However, I would suggest that the vast majority of Americans are recognizing that their health care costs are skyrocketing. Some who are among the organized work force are seeing give-backs at the bargaining table, others are seeing higher and higher out-of-pocket costs, and so I do believe that to the extent we can convince them that some form of a national system will do a better job of controlling their out-of-pocket costs better than the current system, I think the vast majority of Americans would support such a program.

Chairman ROCKEFELLER. Yes.

Ms. BURGESS. Mr. Chairman, I think it's quite interesting that so many people who are at a pretty high level of income are very much concerned about the long-term care problem because of their parents. They have a deep feeling that something needs to be done. So, I think even some of the people who, perhaps, would not benefit as much from the standpoint of cost are concerned because of the potential impact of family members—their parents or a child—and ultimately on themselves. And I've talked to one person who said if we had long-term care for everyone my daughter would be in much better shape because her baby, who was born deformed, would have long-term care.

So, I think we have to look at the broad picture of what might happen as we make choices about who should be covered and how much a program might cost. Not everyone would feel that it was a mistake to have a higher cost, perhaps, in their individual cases because everybody would be helped.

Chairman ROCKEFELLER. Yes; one more and then we're going to go to the next panel.

Ms. ROSENBAUM. I think if you'd asked the question 10 years ago you might have gotten a somewhat different response. I think that it's getting so much more difficult to deliver high value benefits and the amount of wages and other compensation that collective bargaining procedures are having to forego in order to keep high medical compensation means that you have, for unfortunate reasons probably, options available today in terms of long-term recommendations that you might not have had 10 years ago. And I think it would be a mistake to focus on the small number of employees who will continue, over and above whatever basic benefits you recommend for the Nation, to be able to secure for themselves through voluntary negotiations, it would be a mistake to allow that to drive the bigger question of what all Americans have.

Chairman ROCKEFELLER. All right. We need to stop at this point because we have three more panels. I want to thank all of you very, very much for your courtesy, for being here, and for the wisdom that you've given to us. Thanks a lot.

Our next panel, panel No. 3, is business. Bruce Mueller is the vice president and corporate director of benefits and personnel systems, Motorola and he is speaking on behalf of the National Association of Manufacturers; John Motley is director of Government relations, National Federation of Independent Business; and Thomas Burke is from A. Foster Higgins & Co. Gentlemen, we welcome you. And Mr. Mueller, when you're settled, sir, we would welcome your testimony.

Mr. MUELLER. Good morning.

Chairman ROCKEFELLER. Good morning.

STATEMENT OF BRUCE A. MUELLER, VICE PRESIDENT AND CORPORATE DIRECTOR OF BENEFITS AND PERSONNEL SYSTEMS, MOTOROLA, INC., ON BEHALF OF THE NATIONAL ASSOCIATION OF MANUFACTURERS

Mr. MUELLER. Thank you. I do appear on behalf of the National Association of Manufacturers, commonly known as NAM, with over 13,500 member companies. We at Motorola are very active with NAM and its policy committees.

Chairman ROCKEFELLER. Are you dead, or your microphone, rather? Oh, yes, good shape.

Mr. MUELLER. Temporarily. We want to thank you for holding the sessions today. My comments will summarize the main points and the recommendations in the written testimony, which has been provided to the Commission.

The current state of health care coverage in the United States is a serious societal problem that is of great concern to us in business. Motorola and NAM believe that reform of our health care system must focus on access, quality, and cost, and should be dealt with in an integrated fashion.

In the area of quality, some medical care is ineffective and inappropriate and potentially injurious, largely because we lack a mechanism to define what effective care is. The RAND Corp. has estimated that eliminating the use of inappropriate procedures could save 10 percent of the U.S. health care budget, or $50 billion per year, in unnecessary care. The interrelated problems of access to, cost, and quality of health care will require systemwide improvements. This is a major task and can only be accomplished through the collective efforts of both the public and private sectors.

There are a number of current legislative proposals which would require all employers to provide health coverage for employees and their dependents. While such proposals would improve health care coverage for noncovered workers and some covered workers and gradually increase access for others, they would do so at a great cost to our economy. It would also have a negative impact on our health care system. NAM and Motorola oppose the mandating of employer-provided benefits as a means of improving access for the noncovered. Increased health care utilization and higher benefit levels resulting from this mandate would add to the already high health care inflation rate.

Our recommendations to improve the health care system include the following: One, the purchaser, provider, and payer cooperation. Elements of such a program should include public information on providers, incentives to encourage employer-based coverage, and improved management of public programs.

Two, State data laws that would make information publicly available to assist in better buying decisions. All States should have laws requiring data disclosure and compliance as a condition of Federal Medicaid funding.

Next, employees should be educated consumers of health care. Individual responsibility for one's own health should be stressed in order to promote appropriate knowledge and use of the health care system. Greater emphasis also needs to be placed on preventive health care. The medical liability reform should be pursued at the national level. Medicare should continue to improve hospital and physician payment methods. Also Medicare and Medicaid should improve their efficiency with greater use of managed care and alternative delivery systems. All health plans should be exempted from State benefit mandates through an ERISA-type preemption to make health coverage more affordable to small business. State benefit mandates add significant cost to the health coverage typically purchased by small business and results in decreased access to health care.

Next, arrangements for group purchasing of health care coverage should be encouraged. Multiemployer trusts enable firms and workers to join together to obtain favorable underwriting terms, but restrictive State laws and other barriers hinder such arrangements. We should also provide tax incentives to permit employers and employees, at their option, to prefund retiree health benefits. The immense growth in future employer health spending as a result of retiree health obligations under the Financial Accounting and Standards Board rules will otherwise restrict the availability and level of health care for all of our employees, including our retirees. Employers must make greater efforts to aggressively manage health care costs through efficient plan designs that make judicious use of deductibles and copayments and cost sharing.

Finally, Medicaid should be expanded to cover more of the noncovered poor and low-income workers. Such coverage should be phased in to assure parallel improvements in quality and efficiency.

Employers such as Motorola cannot continue to compete effectively locally or in the global marketplace unless the continued escalation of health care costs and its expectations is harnessed. The success of reforming the health care system depends on a sustained and coordinated effort by all concerned parties; business, labor, government, providers, payers, and consumers, not through the mandating of benefit coverage.

It is critical that we develop a sound, sustainable health care system, one that delivers the health care coverage that is really needed, at a realistic cost. We in business offer our assistance in working with you toward a solution to this complex societal problem. Thank you.

[The prepared statement of Mr. Mueller follows:]

MANUFACTURING CREATES AMERICA'S STRENGTH

TESTIMONY OF
BRUCE A. MUELLER
VICE PRESIDENT AND CORPORATE DIRECTOR OF
BENEFITS AND PERSONNEL SYSTEMS
MOTOROLA INC.

ON BEHALF OF THE
NATIONAL ASSOCIATION OF MANUFACTURERS
ON
ACCESS TO HEALTH CARE: OPTIONS AND FINANCING

BEFORE THE
U. S. BIPARTISAN COMMISSION
ON COMPREHENSIVE HEALTH CARE
(PEPPER COMMISSION)

OCTOBER 24, 1989

NAM

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The National Association of Manufacturers is a voluntary business association of more than 13,500 member companies and subsidiaries, large and small, located in every state. Members range in size from the very large to the more than 9,000 smaller manufacturing firms, each with fewer than 500 employees. NAM member companies employ 85 percent of all workers in manufacturing and produce more than 80 percent of the nation's manufactured goods. NAM is affiliated with an additional 158,000 businesses through its Associations Council and the National Industrial Council.

SUMMARY

Motorola Inc. and the National Association of Manufacturers believe that reform of our health care system must focus on cost control and quality improvement, particularly in the buying decisions for health care, in conjunction with a phased expansion of access for those who do not have health care coverage. Lack of health coverage for a large segment of our population is a serious societal problem and of great concern to business. It is our view that cost, quality and access should be dealt with in an integrated fashion.

As such we recommend: (1) Purchaser-provider-insurer cooperation with an emphasis on quality improvement; (2) State data laws that would make information publicly available to assist in better buying decisions; (3) Employees should be educated consumers of health care; (4) Medical liability reform should be pursued at the national level; (5) Medicare should continue to improve hospital and physician payment methods; (6) Medicare and Medicaid should improve their efficiency with greater use of managed care and alternative delivery systems; (7) All health plans should be exempted from state benefit mandates through an ERISA preemption to make health coverage more affordable to small business; (8) Arrangements for group purchasing of health coverage should be encouraged; (9) Provide tax incentives to permit employers and employees at their option to prefund retiree health benefits; (10) Employers must make greater efforts to aggressively manage health costs through benefit redesign and other means; and (11) Medicaid should be expanded to cover more of the non-covered poor.

Short-term solutions, such as mandates that focus on single problems and place the burden on single sectors of society, are doomed to fail in the long run.

The success of system reform depends on a sustained and coordinated effort by all concerned parties--business, labor, government, providers, insurers and consumers. It would be a serious mistake to search for scapegoats when we all bear some of the blame and therefore the responsibility for solving this complex societal problem.

Testimony of
Bruce A. Mueller
Vice President and Corporate Director of Benefits
and Personnel Systems
Motorola Inc.

on behalf of the
National Association of Manufacturers
on Access to Health Care: Options and Financing
before the U.S. Bipartisan Commission
on Comprehensive Health Care
(Pepper Commission)
October 24, 1989

Mr. Chairman and members of the Commission, I am Bruce A. Mueller, Vice President and Corporate Director of Benefits and Personnel Systems at Motorola. Accompanying me is Sharon Canner, NAM's Assistant Vice President of Industrial Relations. Our company employs over 61,500 people in the United States. Adding together the dependents of these workers and our retirees we provide health coverage to approximately 130,000 individuals at a 1989 cost of over $141 million.

Motorola is an active member of the National Association of Manufacturers' policy committees. I am pleased today to appear on behalf of NAM's over 13,500 member companies, 9,000 of whom have fewer than 500 employees. I wish to thank you Mr. Chairman, for holding this hearing on access to health care, a subject of great concern to business.

This testimony will comment on the cost and quality of health care access, and offer NAM's and Motorola's recommendations on ways to improve our health care system.

HEALTH CARE ACCESS, COST AND QUALITY

The Uninsured

The March 1987 Current Population Survey (CPS) conducted by the U.S. Census Bureau reported that in 1986, 83 percent of Americans under age 65 were covered by health insurance. Three-quarters of those covered obtained coverage either through their own employment or that of a family member. The rest were covered through a mix of Medicaid, Medicare, Champus, private insurance or other sources.

An estimated 37 million or 17 percent had no coverage. More recent statistics have put this number nearer 31 million uninsured. This percentage was the same reported in 1984 and 1985, but substantially greater than that reported in the early 1980s. Of the non-covered, nearly one-half were workers and another one-third were children under age 18. Only 18 percent of those not covered were nonworking adults. Uncovered workers tend to work at lower-paying jobs, some are self-employed, employed in retail trade or services, employed part-time or intermittently or work for small firms that do not provide health benefits. A small percentage are medically uninsurable.

Coverage for manufacturing firms is high. A January 1989 survey of NAM members revealed that of companies with fewer than 25 employees, 96 percent offered benefits to workers and 94 percent offered such benefits to dependents as well. For larger companies the coverage rates neared 99 percent. While some self-selection in the survey may have occurred, other studies, such as that conducted by the U.S. Small Business Administration, tend to confirm these numbers.

Medicaid, enacted in 1966 to provide health coverage for the poor, today covers only approximately 40 percent of those at or below the federal poverty line, largely as a consequence of differences in state eligibility criteria. Added to this problem is the declining percentage of Medicaid dollars actually going to low-income persons. Currently, benefits for the disabled and long term care services for the elderly use 60-65 percent of the Medicaid budget.

We don't believe it is acceptable in this day and age to have so many of our citizens without health care coverage. We must address this need. But in so doing, we must also address pressing cost and quality considerations.

Cost and Quality

National health care expenditures rose by 8.5 percent in 1986 and 9.8 percent in 1987 which represented over 11.5 percent of the Gross

National Product (GNP) going for health care. Health benefits, according to the Employee Benefits Research Institute (EBRI), have become a major part of labor costs.

From 2.4 percent of total compensation and 23 percent of total benefits in 1970, health costs grew to 5.4 percent of total compensation and 33 percent of all benefits in 1987. A January 1989 survey of NAM members confirmed that the cost of providing benefits had skyrocketed and consumed an average of more than one-third of net profits. Offsetting quality or service gains have not emerged to justify these cost increases.

With regard to our own company, we have implemented most of the state-of-the-art in cost management and managed care techniques, yet we continue to incur yearly cost increases in the 10-12 percent range, and that affects Motorola's competitiveness. Such health care costs surely impact the competitiveness of other companies, and ultimately, consumers are affected through the cost of goods and services.

The plight of small companies is especially serious. These employers have little or no ability to bargain with insurers and providers and are faced with the hard choices of reducing benefit coverage, increasing cost-sharing or dropping health benefits altogether. The Will-Burt Company with 225 employees in Orrville, OH was recently notified by its insurance company that premiums in 1990 would rise 61 percent. (Last year the increase was 52 percent). Conversations with this company indicate that benefit reduction and increased employee payments are strongly being considered as well as reducing R&D and equipment buying.

The underlying causes of inefficiency in the U.S. health care system are numerous, including a payment system that encourages uneconomical buying decisions, uneven quality and appropriateness of care, a bias towards excessive and sometimes inappropriate use of technologies, and a malpractice liability environment that significantly escalates health care costs.

On the issue of quality, some medical care is ineffective or inappropriate and potentially injurious largely because we lack a mechanism for defining just what "effective" care is. The Rand Corporation has estimated that eliminating the use of inappropriate procedures could save 10 percent of the U.S. health care budget or $50 billion a year in unnecessary care.

The problems of access to health coverage, and the cost and quality of care are interrelated issues that must be addressed in an integrated fashion. We believe access should be expanded, but phased in to assure that increased participation in the health delivery system does not lead to greater health cost inflation and that services be allocated to the most needy. Failure to address these difficult choices now will eventually lead to future rationing of health care.

The interrelated problems of access to, cost and quality of health care will require system-wide improvements. This is a major task that can only be accomplished through the collective efforts of the public and private sectors. Following comments on health care coverage mandates and alternatives, we will present further detail on suggested improvements.

Health Care Coverage Mandates and Alternatives

Current proposals require all employers to provide health coverage for employees and their dependents, by defining a specified package of benefits, limiting employee/employer costs and out-of-pocket spending, and establishing subsidies for small business. A Medicaid-like program would serve all persons below the federal poverty line.

While such proposals would improve health care coverage for non-covered workers and gradually increase access for other unserved Americans, it would do so at great cost to our economy and have a negative impact on our health care system.

NAM, and Motorola, oppose the mandating of employer-provided health benefits as a means to improve access for the non-covered. Increased health care utilization resulting from this mandate would exacerbate already high health care inflation rates. It is essential that we first deal with the fundamental problems of our health system--an inefficient payment system, uneven quality and appropriateness of care, overcapacity in some areas and undercapacity in others, and the inefficiencies of defensive medicine and high medical malpractice costs. Failure to address these problems will ultimately lead to rationing.

While some companies favor mandated benefits to "level the competitive playing field" in the U.S., raising manufacturing costs by mandating benefits would diminish American competitive strength in the global marketplace and likely jeopardize the job creation and job security of those we are trying to help. Small manufacturers would be especially impacted by mandates. We believe in giving employers the flexibility to design benefit programs that meet the specific needs of their employees. Flexibility means offering choices to employees as well.

While we support expanding coverage, we strongly believe this must be based on a thorough understanding of the composition of the estimated 31 million uninsured. Phased expansion must be based on priorities that recognize and strive for greater efficiencies and accountability in the delivery of health care.

Senator Hatch recently introduced S. 1274, the Comprehensive and Uniform Remedy (CUR) for the Health Care System Act of 1989. This bill would improve pre-natal care, remove barriers to facilitate less expensive health insurance through state risk pools and preemption of state benefit mandates, enhance medical effectiveness research to improve quality, address medical liability reform, and encourage workplace prevention programs. NAM, and Motorola, support the provisions of S. 1274.

In particular, we believe the provision on medical liability shows promise in addressing both costs and quality of care. The provision would increase the authorization for patient outcomes research to $100 million per year; and authorize the DHHS Secretary to establish treatment practice guidelines to be used as a defense in medical malpractice litigation.

The use of guidelines as a defense in litigation could potentially help curb the costs of medical liability. It is estimated that malpractice premiums are about 1 percent of health costs (which totalled $600 billion in 1988) with the secondary costs of defensive medicine adding considerably to that figure. It is unclear what the legal challenges may be to this approach, but it is important to begin seriously pursuing this course of action in the fight against health care inflation.

NAM Recommendations

In May, the NAM released a white paper--"Meeting the Health Care Crisis"--and results of a membership survey on health costs. We request that the full text of that document be included for the record.

Our recommendations focus on cost control and quality improvement, particularly in the buying decisions for health care, in conjunction with a phased expansion of access for those who do not have health care coverage. It is our view that cost, quality and access should be dealt with in an integrated fashion.

o All purchasers and providers of health care should cooperate to achieve a cost-management system that defines the health care product and judges its quality. Elements of such a program should include sound public information on providers, incentives to encourage employer-based coverage and improved management of public programs. A major effort should be made to develop a process to provide continual information on health care quality and appropriate treatment.

Purchaser-provider-insurer cooperation is essential if we are to achieve our goals. In areas of quality we should strive for effectiveness to determine whether or not treatment improves a patient's condition or outcome; appropriateness to determine whether intensity of treatment is consistent with the severity of a condition; and efficiency to determine whether cost of treatment is consistent with outcome.

o Data on individual hospitals and physicians should be publicly available to assist purchasers in making intelligent buying decisions. All states should have laws requiring data disclosure, and compliance should be a condition of receiving federal Medicaid funding.

A number of states, including Pennsylvania and Iowa, have already enacted such laws. Good information is essential to informed decision-making for all purchasers of health care.

o Employees should be educated consumers of health care. Individual responsibility for one's own health should be stressed. Employees should be instructed on how to use the health care system and health benefits better, and greater emphasis should be placed on preventive health care. We also believe that education on basic health care should begin in the schools so that future generations of Americans will be more informed consumers. Where collective bargaining agreements exist, labor unions should strive to support these education efforts.

o Medical liability reform should be pursued at the national level with limits placed on contingency fees and punitive damages. We should strengthen standards for negligence and establish no-fault compensation for certain areas of liability.

o Medicare should continue to refine the Diagnostic Review Groups (DRGs), to smooth out irregularities and update payment rates. New methods should be developed to replace the current prevailing fee environment for paying doctors.

We support the Senate Finance Committee's approach to paying physicians under Medicare. This approach combines both volume controls and attention to medical effectiveness. It sends a signal that "gaming" the system will be more difficult in the future. Greater discipline on physicians is expected to have some spillover effect to the private sector just as DRGs did for hospital payments.

o The federal government should use its purchasing power under Medicaid and Medicare to encourage a more efficient marketplace. Public programs should stress the use of managed care to hold down costs and improve efficiency.

o All health plans should be exempted from state mandated benefit laws through an ERISA preemption.

State benefit mandates add significantly to the cost of health coverage typically purchased by small business. According to a 1988 study by the National Center for Public Analysis, 9.3 million people lack health coverage because of state regulation requiring mandated coverages for certain benefits and services.

o We should encourage coverage arrangements, such as multi-employer trusts (METs), that enable groups of firms and workers to join together to obtain more favorable underwriting terms. Restrictive state laws and other barriers should be eliminated to facilitate these arrangements.

o Proposed Financial Accounting Standards Board (FASB) rules for retiree health obligations serve to highlight the immense growth in future employer health care spending--spending that will restrict the availability of health care for all employees. Should these rules be adopted as proposed, corporations should be provided tax incentives to prefund these benefits at their option.

o Employers must make a greater effort to control the costs of their health care programs, focusing on employee education, quality and appropriate care, and adopting health plans that yield the best health outcomes and make judicious use of deductibles and cost-sharing.

Some employers, like Motorola, have taken an aggressive stance at cost control by implementing managed care, redesigning benefit plans, and requiring data from providers with a view toward using the most efficient hospitals and physicians. Much more needs to be done. NAM is currently developing information on these initiatives which will be disseminated to our members.

o Medicaid should be expanded to cover more non-covered poor with a buy-in for low-income workers. Coverage should be phased-in to assure parallel improvements in quality and efficiency, targeting those most needy with priority given to children.

CONCLUSION

The success of system reforms depends on a sustained and coordinated effort by all concerned parties--business, labor, government, providers, insurers and consumers. It would be a serious mistake to search for scapegoats when we all bear some of the blame and therefore the responsibility for solving this complex societal problem.

Fundamentally, this means as consumers of health care we all must take greater responsibility for our own health and use of health services as a means to improve the current system. The problems of our health care system are multifaceted--cost, quality and access. Addressing one problem without due attention to the other is doomed to failure in the long run. Thus, we strongly urge an integrated approach if we are ever going to solve this critical societal problem.

Chairman ROCKEFELLER. Thank you, Mr. Mueller. Mr. Motley.

STATEMENT OF JOHN J. MOTLEY III, DIRECTOR OF FEDERAL GOVERNMENTAL RELATIONS, NATIONAL FEDERATION OF INDEPENDENT BUSINESS [NFIB]

Mr. MOTLEY. Thank you, Mr. Chairman. First of all, I'd like to thank you and the Commission for the opportunity to share the views of NFIB's 570,000 members today.

I would like to call to your attention one of the appendices that we have submitted to the committee, as part of our lengthy testimony, which I'll try to summarize. That is a 1989 NFIB survey entitled Small Business and Health. We polled some 18,750 members and received 5,368 responses, which is a rather large sample. I believe it will give you a good insight into the attitudes and practices of the small business community in the health area.

First of all, Mr. Chairman, I would like to say that we at NFIB believe that over the long haul the current system of providing for access to health care for Americans has served the country fairly well. If you take a look at the amount of the population which was covered in 1940, you're talking about roughly 40 percent of the individuals in the United States had health care. In 1986 that was almost up to 85 percent, almost a 1-percent increase each year between 1940 and 1986. There has been some stagnation in the increase in coverage since 1986.

But we do not believe the system should be turned on its head or that it should be completely replaced with another system. Instead we believe that we should take a look at some of the things that may be causing this stagnation or the change in the rate of increase of coverage, such as the rapidly rising cost of health care, or two, the shift away from individual responsibility in the health care area.

The key, from a small business standpoint, Mr. Chairman, is affordability of health insurance. Affordability is a combination of the cost of health insurance and the profitability of the firm. In a 1986 NFIB survey entitled Problems and Priorities, health insurance costs and availability were the No. 1 problem stated by NFIB members. No. 1 out of 78 problems that they had to choose from.

And there is ample evidence in the recently cited survey in 1989 that health insurance costs are indeed a serious problem. In fact, 92 percent of those members responding stated it as a serious problem and 91 percent said that it was prohibitively expensive. In terms of affordability, 38 percent of the respondents to our 1989 survey indicated that they took less than $30,000 a year out of their businesses, 44 percent said that profitability was the reason why they did not provide health insurance, and 72 percent responded that profitability was the reason that they did not provide the type of policy that they would like to provide for their employees.

Therefore, the key from our standpoint, Mr. Chairman, is how do you reduce costs? First of all, I think that the primary long-term answer to this problem is health care cost containment. And we at NFIB are not experts in the area of health care and do not have an awful lot of ways right now to suggest to do this, but we'll be taking a look at the problem.

No. 2, and we're not experts in the insurance area either, but there is something dramatically wrong in the availability of health insurance and the cost of health insurance to small employers today, where you have health care costs rising at roughly twice the rate of inflation, but insurance costs rising for small businesses at somewhere between 20 percent and 200 percent a year. And there are a number of examples of this in the testimony which I have submitted, Mr. Chairman.

Third is the area of Government actions which continue to drive up the cost of health insurance for small employers. ERISA, which was passed in the mid-1970's, allows for State mandates. Mandated coverages stating that insurance companies must provide these coverages in any insurance policy which is sold in the State drives up the costs of health insurance for smaller businesses. My own State of Maryland, which has 32 such mandates, the estimated increase in the cost is between 20 and 30 percent for a health insurance policy for a small firm who wishes to purchase it in that State. In addition, such things as COBRA [Consolidated Omnibus Budget Reconciliation Act] and section 89 also considerably drive up the cost of providing health insurance for smaller employers.

On the incentive side, we have tremendous discrimination against the self-employed who only receive a 25-percent deduction for their own health insurance premiums, while individuals who happen to be officers of corporations receive a full 100 percent. There is a significant portion of the 37 or 31 to 37 million Americans who do not have health insurance who are self-employed, approximately 22 percent, and they employ roughly 20 to 25 percent of all of the individuals in the country.

On the individual side, a very strange phenomena has taken place in that we are actually now discouraging individuals in the tax area from purchasing health insurance for themselves. There used to be a line item on the 1040 form for a deduction for the premium for health insurance. Today that has been eliminated and it is lumped with all of the other deductions that an individual has, if they itemize deductions, for medical or health care.

Last, Mr. Chairman, in conclusion, we at NFIB believe that mandates, new taxes, or fees or other disincentives are not the answer from a small business standpoint. In fact, as an answer they could actually prove disastrous.

If we take a look at the demographics of the small business community in this country, we see that many of them are simply not making enough money to go out and purchase the type of health insurance which is available to them in the marketplace. Again, I refer to the 38 percent who take out less than $30,000 a year from their business; 10 percent take out less than $10,000 a year. If you combine that with the demographics of the population that is uninsured, where one-third of them make less than $10,000, I believe that you have the recipe for a disaster.

It doesn't take a genius to see what the reaction would be from the small employer who is suddenly faced with providing health insurance for an individual at a cost of $2,000 to $3,000 a year. In fact, in the NFIB survey at a cost of $1,200 to $1,800 a year, 46 to

50 percent of the respondents said they would either go out of business or release all of their employees and continue in business.

Thank you very much, Mr. Chairman, for the opportunity to share our views. I'll try to answer any questions that you might have.

[The prepared statement of Mr. Motley follows:]

NFIB

National Federation of
Independent Business

EXECUTIVE SUMMARY

JOHN J. MOTLEY III
DIRECTOR, FEDERAL GOVERNMENTAL RELATIONS

NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Before: Pepper Commission on Comprehensive Health Care
Subject: Health Insurance Cost and Small Business
Date: October 24, 1989

NFIB agrees with the goal that all Americans should have access to quality health care regardless of income. The problem lies with the means of effectuating that goal.

NFIB constantly polls its membership and we have conducted several comprehensive health surveys. In 1986 the cost of health insurance was rated the number one problem faced by small firms. In our most recent survey in 1989, eighty-nine percent of our members surveyed listed the cost of health insurance as becoming prohibitively expensive. This helps to explain why the number of small firms offering health insurance has stagnated since 1986, after increasing since the 1970s. In addition, for less than the one third of our membership that do not provide health insurance, the cost of health insurance continues to prevent them from offering it as a fringe benefit.

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The Guardian of
Small Business

Small business means a family business atmosphere. They want to offer health insurance and believe it is an important fringe benefit. In fact, it is the second most common benefit offered after paid vacations. Unfortunately, escalating costs present a problem for small firms. Increases from 20 to over 200% are not uncommon. It is also not uncommon for those increases to be monthly or quarterly, or to occur despite a healthy track record.

NFIB member Ray Morgan, for example, owns a business in Algona, Iowa with seven employees. He has experienced enormous increases in health insurance policies.

- In approximately the past 10 years, he has had three health insurance carriers. The first carrier was dropped in July, 1988 after significantly increasing the premiums by 57% to $837.05/month. Unfortunately, changing carriers did not keep his premiums from further escalating.

- The second carrier began its coverage in August, 1988. For all seven employees the premium in August, 1988 was $1470.69/month.

- That was swiftly followed by a 4% increase in September, 1988, bringing the total premium cost to $1525/month.

- In May, 1989 the premium was increased to $2231/month.

- Then in July of this year, his premiums were increased again to $2685/month.

- Mr. Morgan has since switched carriers. The current premium is now $1634/month or $19,608/year (obviously not including any future premium increase).

From August, 1988 until July, 1989, Mr. Morgan's premiums had increased by 83%. In addition to the premium increases, the insurance carrier also increased the employee deductible from $100 to $250 and increased the coinsurance cap from $5,000 to $15,000. During the ten months with the first carrier, Mr. Morgan's business had no major claims filed.

Take, for example, another small business. This person is a self-employed woman working in the District of Columbia. Her premiums were $200.00 a quarter in 1989. For the next quarter, the carrier wanted to raise her rates to $900.00. She did not report any bad health experience. Neither of these stories are unique.

As mentioned earlier, those firms not offering health insurance usually cite the cost of health insurance as a primary factor. Other reasons for not providing coverage include:

- insufficient profits
- not in business long enough
- employee turnover too great
- many employees covered elsewhere, and
- employees prefer a wage increase.

On the other hand, some of the reasons for the high costs of health insurance for small firms include:

- high administrative costs. (In fact, a large firm receives 95¢ of benefits for each dollar spent while a small firm only receives 75¢ for each dollar spent.)
- insurer fear of adverse selection
- instability of the firm
- too many part-time employees
- lack of expert help in choosing and negotiating plans
- and, surprisingly, a large number of those surveyed indicated that they were "too small" or too new to receive group coverage.

Clearly, something has happened to the small business insurance market. In the small business market, there is a pervasive use of experience rating, rather than community ratings, extensive use of age and medical underwriting, and the exclusion of employees from the group. Many insurers are actively and aggressively competing for only the young and healthy.

The second problem that needs to be addressed is cost containment. The cost of health insurance is driven by costs charged by the medical infrastructure. As this Committee knows, health care inflation is running double that of consumer inflation. NFIB believes that cost containment is the only long-term solution to the uninsured problem.

The third aspect of this puzzle is to remove government disincentives for providing health insurance. I will touch on three of those disincentives.

First, the state mandates. There are over 690 state mandates in this country, each mandating a particular type of coverage from mental health to in vitro fertilization. State mandates also drive up the utilization of services. For example, in the state of Wisconsin, mental health care is mandated. Before the state mandate, there were only 70 mental health clinics in Wisconsin; there are now over 400. In Maryland, 32 state mandates have driven up the cost of health insurance 20 percent. In California, over 25 state mandates have driven up the cost 30 percent.

Elimination of state mandates would lower the cost of insurance and permit the offering of a catastrophic, bare bones policy. It is important that we divorce other important social goals from this objective. The objective must remain access to quality health care. It is more important to offer health insurance that covers what can financially ruin a family. State mandates prohibit the offering of such low-cost, catastrophic plans.

Second, the Committee should also consider putting self-employed business owners on the same footing as an incorporated business. The 25 percent deduction should be brought up to the corporate level of 100 percent. EBRI estimates that 22.4% of the self-employed are uninsured. These businesses, in turn, employ a significant number of employees. An incentive to the owner is an incentive to provide insurance for the entire group.

Third, Congress should reexamine COBRA, the continuation of health benefits to former employees and their dependents.

The NFIB 1989 survey offers some interesting insights into what is happening in the small business environment. Clearly, health insurance has become prohibitively expensive, and our members perceive that insurers are not competing for their business. The survey also reveals:

- the cost of health insurance is fairly elastic. A business reaches a point where it explores other options or refuses to provide/continue coverage;

- employees prefer wage increases over benefit increases;

- there is a distinct difference between full-time and part-time employees;

- the provision of fringe benefits is directly related to the firm's profitability and maturity. Over 40% of those surveyed took out of the business less than $30,000 dollars last year.

The bottom line to this discussion rests with five points:

FIRST: Medical inflation must be brought under control

SECOND: The individual must be brought back into the process.

THIRD: Until costs are contained, small firms need help. High costs keep new firms from offering coverage and forces those firms with insurance to rethink their commitment. They cannot absorb these increasing costs, and they cannot pass them along to the consumer and remain competitive.

FOURTH: An examination of underwriting practices, pooling, or reinsurance mechanisms may help with the access factor.

FIFTH: Changes need to be made, but, new taxes, penalties, or mandates are inappropriate.

These points raise some interesting challenges for this Committee to meet. I hope you will take a look at the survey. As someone wise once said, "In simplicity lies difficulties, only in complexity lies solutions."

7944D

LAVELLE AIRCRAFT COMPANY
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October 11, 1989

The Honorable H. John Heinz III
277 Russell Senate Office Building
Washington, D.C. 20510

Dear Senator Heinz:

Many people have been talking about the high cost of Medical Insurance but in the last month the problem really hit home. We are a small manufacturer with 150 employees located in Philadelphia. Our products are used by the U. S. Government and by customers who supply the U. S. Government in the Aerospace Industry.

I'd like to share with you the enclosed letter sent to our employees on September 28th because it more fully defines the dilemma. You will note from the letter that in 1987 our cost for Medical Insurance increased by $26,000 over 1986. In 1988 the increase nearly doubled to $50,000 over 1987; and finally in 1989, the increase doubled once again to more than $101,000. One can also see the cost per employee has increased dramatically.

In these times with Senator Kennedy and others asking for mandated medical protection, one can get an appreciation of the problem. We, the business community and the workers need Government intervention to study the problem and to develop controls over the medical care and insurance industries. The alternative is that no company will be able to afford to provide Medical Insurance.

Very truly yours,

LAVELLE AIRCRAFT COMPANY

Richard Ludwig

Richard Ludwig
President

NOTICE TO ALL EMPLOYEES: 9/28/89

The cost of our Medical Insurance has increased to the point where we can no longer afford to provide the present level of coverage. The rates for the coming year have been increased 34.3% over this year; and since 1986 the rates have increased 81%. The percentage level is difficult to understand, so translating this into dollars -

	Total Cost	Cost Increase
In 1986, it cost Lavelle	$ 219,000	--
In 1987, it cost Lavelle	245,000	$ 26,000
By 1988, the cost was	295,000	50,000
And now the cost would be	396,000	101,000
	3 Year Total,	$177,000

Dividing this by 150, the approximate number of employees, this works out to -

$ 1,487.00 per employee in 1986	--
1,633.00 per employee in 1987	$ 173.00 increase
1,967.00 per employee in 1988	334.00 increase
2,640.00 per employee now	673.00 increase
3 Year Total,	$1153.00 increase

This is the single most expensive element of our business and because of our high claims (actual claims by our employees last year exceeded the premiums paid), we are unable to obtain equal coverage from any other supplier.

Therefore, effective November 1, 1989, we're revising our Medical Insurance Plan. We are going to a two tiered plan. That is, the company will pay for Blue Cross and Blue Shield for the employee and family with a $250.00 deductible on Blue Cross claims and a $500.00 deductible for Major Medical claims. There will be no change on the Blue Shield coverage. Even with this tightening, the company's cost will increase by more than $41,000 over this year's cost.

The second tier is for anyone who wants to continue with the same coverage as they have had. That is, no deductible for Blue Cross claims and $100.00 deductible for Major Medical claims. Those who do want to continue the coverage at that level may do so at their own expense. We will make payroll deductions for the proper amounts. Please review the attached chart to determine what the additional cost will be. Note also that because of the change in our basic plan, there will be a change to the amount the company will pay for HMO coverage.

Please complete the attached form indicating your choice of Medical Insurance to be effective November 1, 1989.

I sincerely regret having to make this change, but we simply cannot continue to carry the burden alone for this uncontrollable and ever increasing expense.

Richard Ludwig

Richard Ludwig, President

NFIB

National Federation of
Independent Business

WRITTEN
STATEMENT OF

JOHN J. MOTLEY III
DIRECTOR, FEDERAL GOVERNMENTAL RELATIONS

THE NATIONAL FEDERATION OF INDEPENDENT BUSINESS

Before: Pepper Commission on Comprehensive Health Care
Subject: Health Insurance Cost and Small Business
Date: October 24, 1989

On behalf of the over 570,000 small business owner members of the National Federation of Independent Business (NFIB), I want to thank the Subcommittee for the opportunity to testify today. The NFIB membership comes from all walks of life reflecting the national small business community in its distribution among standard industrial classifications (SIC) codes. That is, we have similar percentages of members in the construction industry, the manufacturing industry, wholesale, retail, etc., as exist in the national business profile. This is important with respect to our survey data.

For NFIB members and their more than 7 million employees, much is at stake in the current debate over mandating health benefits. The case studies in the appendix express in real life terms precisely what our data explain in statistical terms--that despite the desire to help employees, small firms are being priced out of the health insurance market and sometimes, if they provide benefits, out of business.

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The Guardian of
Small Business

While NFIB is a recognized authority on small business, it is not an expert in the health care industry or in the insurance industry. Therefore, my remarks are primarily directed to a description of the attitudes and operational characteristics of the small business community.

Overall, it is our view that the health insurance market for small business has failed. The current underwriting practices of the health insurance industry, the use of experience, rather than community ratings, combined with the exodus of large firms to the fairly unregulated environment of self-insurance has left small firms in a difficult, if not impossible situation. Two words that sum up this situation: unaffordable costs.

Background

NFIB has conducted three national surveys in this general area. The first was done in 1978 and is entitled National Health Insurance Report on Small Business. The second, conducted in late 1985, is entitled Small Business Employee Benefits. A third is in the process of being thoroughly analyzed; however, the preliminary results are shared later in this statement.

In addition, NFIB's 1986 Small Business Problems and Priorities identified the rising cost of health insurance as the number one problem facing small business. It was also one of the top concerns raised by the 1986 White House Conference on Small Business.

The vast majority of small business owners view health insurance as a fringe benefit -- to be voluntarily negotiated between the owner and the employee. If health insurance is to move from being a benefit to being a right, its provision must shift away from the business to society or to the individual. Little discussed in the debate over the uninsured is the concept of an individual obligation to purchase health insurance.

The overwhelming majority of firms employing people in the United States are small businesses. About 60% have fewer than 5 employees, and nine out of ten have fewer than 20. Small firms produce over one third of the Gross National Product in the United States. That output makes American small business the world's fourth largest economy.

According to David Birch of MIT, 70% of the 14 million new jobs created in the past decade are in small businesses, yet 50% of all small firms turn over in a five-year period. Approximately 2 of every 3 persons get their start in a small firm. Clearly, the engine of the U.S. economy lies in the small business sector.

For NFIB's small business owner members and their more than 7 million employees, much is at stake in the current debate over health care and health insurance. The small business community is in the middle of the proverbial rock and a hard place -- small business owners want to provide health insurance but many are unable or cannot afford to do so.

Small Business and Health Insurance

A. The Market

The number of small business owners providing employee health insurance coverage steadily increased from 1978 to 1986 but has since stabilized or even declined. All data indicate that the stabilization is attributable to two basic factors: first and foremost, the escalating and unpredictable cost of health insurance premiums. Second, employees seem to voluntarily prefer salary increases to fringe benefits. With the unique workforce employed by small firms -- unique in terms of age spread and hours employed -- employee demand plays a large role in the provision of any fringe benefit. Increased cash compensation, rather than benefit compensation, is preferred.

Nearly two thirds of small businesses offer health insurance, and well over 80% of these health insurance plans carried an option for dependent coverage. According to NFIB surveys and the SBA, the majority of small firms offering coverage paid 100% of the premium costs, in sharp contrast to their much larger corporate counterparts.

Small businesses tend to offer a hierarchy of benefits which expands either as the firm matures, becomes profitable, and/or increases in size. Small business owners, as a group, provide their employees with a wide variety of benefits. Paid vacations and health insurance are the two most common and offered in that order. In addition, larger small firms are most likely to provide a wider selection of benefits to a larger number of employees than are the smallest firms.

No single reason dominates a small firm's decision not to offer health benefits. The most frequently cited reasons are:

- premium expense
- part-time or full-time work status
- employee turnover too great
- employees already covered under a spouse or parent policy (secondary wage earners)
- employee not with the firm for a sufficient amount of time
- insufficient firm profit
- do not qualify for a group policy.

The latter two received the heaviest response rate in the 1989 study and again relate directly back to costs which are influenced by adverse selection. Costs are even greater if the employee is a part-time worker.

B. The Premiums

Providing health insurance is much more costly to small firms than to their larger counterparts. By their very nature, small firms are labor intensive and employ many part-time employees. Most small business owners typically have lower median incomes than the average wage and salary earners. This simple fact translates to a simple business decision--until a profit is realized, employment expenses are kept at a minimum, yet competitive, level and risks are also minimized. Escalating, and unpredictable, premium costs represent a large risk that many small, new, or marginal firms are unable to shoulder.

Several external factors enter into the equation in determining insurance coverage. First, small firms are generally unable to self insure. This forces them to operate under the rubric of costly state health insurance mandates. Empirical evidence has demonstrated that state health insurance mandates drive up the cost of health insurance for firms that purchase it in the open marketplace and preclude the offering of "bare bones" insurance policies. The lack of affordable "bare bones" catastrophic insurance keeps both small firms and individuals out of the market.

Second, according to recent Health Insurance Association of America (HIAA) estimates for 1988, premiums in small firms run 15 to 25 percent higher than those of large, non-self-insured firms. The Small Business Administration estimates that administrative costs for small firms can be as much as 40% higher than their larger counterparts. Unlike policies written for larger firms, risk assessment and administrative costs are more uncertain for small firms and adverse selection problems haunt small firms.

Third, more than three fifths of small firms pay the entire premium; over 87% pay more than half. According to the Small Business Administration, of those firms offering family health insurance plans, 70 percent of the very small firms (1-9) and 55 percent of 10-24 employee firms, but only 34-35 percent of larger firms, pay the entire premium for family coverage.

Fourth, the cost/benefit ratio for small firms is also skewed against them. Of each $100 paid in premiums, small firms derive only $75 in benefits; whereas large firms receive $95 (Nexon, 1987). The reasons for such a differential in both the benefits ratio and higher premium costs include: lack of economies of scale, cost of administration, insurer fear of adverse risk selection, instability in the firm, and the lack of expert help in selecting insurance plans.

The latter present problems when a small firm is faced with escalating premiums or a carrier's refusal to cover--their lack of expertise and time to shop for a better plan or to implement cost containment strategies leaves the small business with few or no options in the marketplace.

Fifth, HMOs and managed care systems are not aggressively marketed to the small business sector, and small business owners tend to be very traditional in their choice of health care providers. Marketing of these alternative care programs requires a basic educational effort for success. Compounding the problem is a plethora of state laws restricting HMOs.

The problems with the startup, marginal, and "high risk occupation" firms are also important factors in determining the ability to obtain health insurance. Underwriting practices routinely exclude these firms or refuse to offer "discount" group rates. Age and preexisting condition underwriting also hurt small firm participation.

SMALL BUSINESS IN 1989: PRELIMINARY SURVEY RESULTS

When asked if "the cost of health insurance is a serious business problem," over 66% of the respondents strongly agreed and an additional 26% agreed with that statement. In addition, 89% found health insurance becoming prohibitively expensive, and respondents offering health insurance had seen increases in premiums in the past year.

The cost of health insurance clearly poses a serious dilemma for small firms. Many believe that increasing costs are making or will make it difficult to compete, and only a minority believe that such costs can be fully passed on to the consumer. Small firms are also discovering that employees continue to prefer wage increases to benefit increases. The younger or more part time the firm's workforce, the greater that preference.

The majority of small business owners do not believe that they have lost good or potentially good employees because of inadequate health benefits. Coupled with dramatically increasing costs and low median business profitability (over 40% reported that they could earn more working for someone else), there appears little hope for expanding coverge to additional small firms without changes in the insurance affordability factor. In addition, the preference by employees for wage compensation, coupled with the fact that of the employers surveyed, few received any inquiry regarding health insurance in the past twelve months, blunts most market pressures to provide insurance.

Contrast the above cost-dominated responses to some of the attitudes held by small business owners. First, 71% believe that every American has a right to basic health care; 74% believe that

Americans should receive a minimum level of health care, regardless of their ability to pay. It is at this juncture, however, that small business owners part company with policymakers in the Congress who wish to impose insurance on businesses. Small business owners do not support mandated health benefits for businesses. They also do not support raising taxes to increase access to health care for low income individuals, much less for the 38% of uninsured individuals who reside in households earning $20,000 or more a year. A consistent research finding indicates that small business owners believe individuals have the first responsibility to obtain health insurance coverage.

Preliminary analysis of the 1989 survey has raised two other interesting features of the small business health insurance market. First, most small business owners do not believe that insurers aggressively compete for their business. Second, of those who do not offer coverage, many independently responded that their business operation was "too small" to get health insurance coverage.

It is difficult to fashion cost containment packages for small firms because of the unique dynamics of a small company, such as: lack of expert help in selecting and shaping plans, adverse selection, employee turnover, inability to self insure, and paternalistic feelings that many times preclude the usual mechanisms of increased deductibles or co-payments.

Any downturn in the economy will also have a significant impact on the availability of health insurance as a fringe benefit. Our data strongly suggest that the offering and/or "richness" of this fringe benefit is directly related to business profitability.

Clearly, the policy solution lies with both cost containment and incentives. Sixty-two percent of small business owners support the government taking a more direct role in bringing health costs under control. Incentives may be the key to unlocking the current problem of premium costs.

Mandate Results

NFIB constantly polls its membership. No position on legislation is taken without approval of a majority of the membership. On the issue of health insurance and health care, small business owners have been loudly registering their concern over the focus of the debate. Mandates, massive expansion of federal government programs, national health insurance, or Canadian system mimicry ignore and exacerbate the real problem for small business--rising health insurance costs.

In April 1987 an overwhelming 89% opposed mandated health insurance (7% favor, 4% undecided). In 1989 small business owners again registered their overwhelming opposition to mandated health insurance legislation.

A consistent finding of our research is that the number one problem facing small businesses is the cost of health insurance. This conclusion was evident in 1986 when out of seventy-five issues polled (from taxes to unemployment compensation to utility rates), the cost of health insurance ranked number one -- even above liability insurance, which was at that time in a crisis state. The problem with the cost of health insurance continues to remain at the top in 1989. In fact, in the newest NFIB comprehensive health study, an astonishing 89% listed health insurance as becoming prohibitively expensive. Options armed at reducing costs are discussed below.

A PARTIAL SOLUTION

Someone wise once wrote, "in simplicity lies difficulties, only in complexity lies solutions". Taxes and mandates are simple solutions for a very complex problem -- both treat the symptoms--the uninsured--and not the disease--runaway medical costs.

NFIB believes that the current system of incentives works. Listed below are additional incentives and policy decisions that will begin to control the cost of health insurance and health care.

1. 100% deduction for health care costs for self-employed individuals.

Current tax law gives a distinct advantage to the business owner who operates in the corporate form as opposed to the business owner who operates as a sole proprietor or partner. In the corporate form, the owner's full health insurance costs, as well as those of his employees, are deductible as business expenses. For the self employed, only the health insurance costs attributable to the employees are fully deductible.

According to the Employment Benefits Research Institute (EBRI), 22.4 percent of self-employed business owners have no health insurance. These business owners make up between six and sixteen percent of all uninsured workers and may employ an even greater percentage of the uninsured. Full deductibility therefore would address a significant portion of the health insurance gap that exists simply by equalizing the treatment for incorporated and unincorporated businesses..

2. Eliminate State Health Insurance Mandates.

Clearly, the most troublesome disincentives for providing health insurance or a fringe benefit are the costs of health insurance and health care. One relatively simple way to lower health insurance costs is to preempt state health insurance mandates. State mandates for specific types of benefit coverage now number over 690. These state mandates have seldom surfaced as a result of constituent demand, but rather have been initiated by well-organized special interest groups, including the providers of services themselves. State mandates range from coverage of wigs (MN) to herbal medicine (FL) to in vitro fertilization (proposed-OH) to special diets for people with Crohn's disease (Mass). Together, they preclude the offering of "bare bones", affordable policies for non self-insured companies -- the majority of whom are small businesses.

The end result of benefit mandates has been a remarkable growth in the number of providers performing the mandated services -- providers who suddenly find that payment for all services is available, indeed mandated, by state law.

In Wisconsin, the passage of a mental health insurance mandate resulted in a phenomenal rate of growth in the number of outpatient mental health clinics -- from less than 40 to more than 900 in ten years.

In Maryland, state mandated insurance benefits were estimated to raise the combined average cost of group and individual Blue Cross/Blue Shield coverage by more than 11% in 1984; outpatient mental health benefits alone were estimated to raise total plan costs by more than 4%. Current estimates tag that increase near 20%. Mandates eliminate the cost control mechanisms provided by comparative choice and increase the cost of health services.

Benefit mandates make coverage unnecessarily expensive due to the legislative dictates of the package's components. They take away the right of the purchaser to select and pay for coverages based on the needs of the workforce and the ability to pay. Buyers end up spending scarce resources on benefits that they may not want or use, or reducing coverage for more essential health services in order to accommodate the extra costs associated with mandates.

State health insurance mandates reflect the uneven field upon which small businesses are playing. The benefits of self insurance are enormous, but very, very few small firms can absorb that high level of risk. Elimination of state mandates will directly result in both premium decreases and will help to stem the overutilization of those services. Such a proposal is essential to any serious effort to contain health insurance costs.

3. Enact Technical Changes in COBRA.

At a minimum, reform of COBRA is necessary. Simple changes would go a long way to helping relieve some of the costly burdens COBRA has placed on small firms. Proposed changes include:

- requiring election of continued coverage two weeks after termination of employment;
- increasing the administrative fee to reflect actual costs;
- changing dependent coverage requirements to preserve the status quo rather than providing an independent right to enhanced coverage; and
- quarterly advance payments.

COBRA may serve a small segment of the employed or "between jobs" population, but its burdens on small firms due to adverse selection is enormous. It will take political courage to enact the above technical changes, but those changes are merely common sense considerations that would equalize the obligations between the employer and the former employee.

4. Tax Credit Incentives.

A credit to payroll taxes, the single most expensive item paid by a small business, would provide a powerful incentive to provide insurance and an adequate offset against rising premiums for those firms that already provide health insurance. A payroll tax credit would reach the substantial part of the small business community that do not have reportable income and could be targeted exclusively to small businesses.

5. Cost-Plus Deduction.

A cost-plus deduction targeted to small firms would permit businesses and individuals to deduct premium costs plus an additional 50%, or some variant thereof, from federal income taxes. The current tax deduction has brought our system a long way. This additional incentive, extended to small firms and individuals, would be directed to those most adversely affected by high medical and insurance costs.

6. Additional Areas of Focus.

- Incentives to encourage individuals to purchase health insurance including the ability for low income persons to deduct the cost of health insurance from federal (non-itemizer's form) and state taxes.
- Existing budget priorities must be reevaluated in light of the uninsured. Such an evaluation calls for shifting among accounts, not a search for new revenues.
- Development of a barebones catastrophic insurance plan. To our knowledge, there is no truly catastrophic, bare bones plan available in the United States. While such a plan would not meet the standards of those who advocate well baby or mental health care, such a plan would meet a serious and dire need -- to provide protection for those unexpected events that could lead to financial ruin.

- Risk pools may offer some relief, however, the pool must be carefully designed (see Appendix #4). NFIB believes that risk pools should not be funded from business excise taxes.
- Bring Medicaid back to its original mandate – to aid the poor. The statistics on the number of poor Americans served by Medicaid is alarmingly low. The program needs to be revitalized and reformulated without increasing its huge bureaucracy or its budget.
- Revitalize the community rating practice for health insurance.
- Remove disincentives to obtain health insurance.
- Explore non-employee based systems.

7. Bring Health Care Costs and Health Insurance Under Control

All involved in the health care field bear some responsibility for the escalating costs, including doctors, hospitals, and individuals who are no longer purchasers but simply middlemen between the health care provider and the insurance carrier. Outcome analyses, protocols and liability/malpractice tort reforms should be examined as part of the solution to drive down the cost of health care. Active consumer participation is necessary to control costs and regulate service usage.

In addition, the issue of the burden of uncompensated care in non-profit hospitals must be balanced against the billions of dollars of foregone local, state, and federal tax revenue. This forgiven tax burden is borne by the rest of the business community and should not be assumed by the federal government.

These efforts must look toward existing funding sources and will necessitate reprioritizing budget functions. The deficit must not be forgotten in the zeal to seek solutions. One path to access is to make health insurance premiums more affordable for employers. A parallel path is to make health insurance more affordable for individuals. That path cannot be blocked by government barriers, like Section 89, state mandates, or by other social goals, such as universal access to specified kinds of medical services. The implementations of the above suggestions and the provision of a bare bones, affordable policy in the private marketplace are the surest, both politically and economically, path toward the goal of affordable access to health care.

SMALL BUSINESS AND HEALTH

(National Totals)
(n = 5,368)

Do you agree or disagree with each of the following statements? (Mark the appropriate answer.)

		Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	NA	Total
3a.	Americans should receive a minimum level of health care regardless of their ability to pay	18	45	9	17	8	3	100%
3b.	Employees prefer wage increases to increases in health insurance benefits	22	51	10	13	2	2	100%
3c.	The cost of health insurance is a serious business problem	66	26	2	3	7	1	100%
3d.	Health insurance should be one of the first employee benefits that employers provide	12	41	9	26	10	2	100%
3e.	An employee health insurance plan is a good way to get coverage for me/my family	16	50	11	15	6	3	100%
3f.	Taxes should be raised to increase the poor's access to health care	3	10	13	42	28	5	100%
3g.	Employers with employee health insurance pay for employers without it	7	22	25	25	16	5	100%
3h.	Higher paid employees show more interest in health benefits than do lower paid employees	12	42	16	23	5	3	100%
7a.	The cost of employee health insurance can be passed on to customers in the form of higher prices	4	26	6	44	19	2	100%
7b.	Full-time employees show more interest in health benefits than do part-time employees	14	59	13	11	2	1	100%
7c.	Drug/alcohol abuse is a national problem	49	43	3	3	1	1	100%
7d.	Drug/alcohol abuse is a problem for my business	4	16	8	47	22	3	100%
7e.	Government should pay the health insurance premiums of those who can't afford to do so	6	20	19	35	18	3	100%
7f.	There is no real competition among providers of health care services	17	39	14	21	6	2	100%
7g.	Business profitability doesn't let me provide the employee health benefits I would like to provide	27	45	8	16	2	2	100%
7h.	Every American has a right to basic health care	18	51	12	13	5	1	100%
10a.	Government must pay a more direct role in health care to bring health costs under control	24	37	8	22	9	1	100%
10b.	Business can't attract first-rate employees without providing health insurance	14	50	10	23	4	1	100%
10c.	Employees should provide full-time and part-time employees the same benefits	2	7	6	57	27	1	100%
10d.	Health care is becoming prohibitatively expensive	51	40	3	4	1	2	100%
10e.	If an employer does not provide health insurance employees should be required to buy their own coverage	6	24	23	36	10	1	100%
10f.	Potential health insurance costs influence my selection of employees	6	26	23	38	6	2	100%
10g.	AIDS is the nation's most serious public health problem	17	32	20	25	4	2	100%
10h.	Administering an employee health insurance plan is (would be) a nightmare	17	35	17	25	2	3	100%
13a.	I would like to provide better (some) employee health insurance	11	53	13	19	3	1	100%

Do you agree or disagree with each of the following statements? (Mark the appropriate answer.)

		Strongly Agree	Agree	No Opinion	Disagree	Strongly Disagree	NA	Total
13b.	Prospective employees show lots of interest in health insurance benefits	6	45	18	27	3	1	100%
13c.	Employers should help rehabilitate employees with alcohol or drug problems	3	19	18	42	16	2	100%
13d.	I could earn more working for someone else than in this business	13	28	16	32	8	3	100%
13e.	Health insurance premiums are often wasted because many employees are covered by policies of other family members	9	41	20	26	2	2	100%
13f.	Employee health insurance should be a reward for loyal service, not just granted everyone	14	35	14	32	3	1	100%
13g.	Government interferes in health care too much	15	29	27	24	4	2	100%
13h.	Older employees are more interested in health benefits than are younger employees	15	51	14	16	1	3	100%
15a.	Employers should be required to provide a basic level of employee health insurance	4	20	8	45	22	1	100%
15b.	Most part-time employees do not need the type of benefits full-time employees do	10	44	18	25	3	1	100%
15c.	Employees should pay at least half of the premiums in an employer-sponsored health plan	14	46	18	18	4	1	100%
15d.	My firm has lost good or potentially good employees because of inadequate health benefits	2	9	17	55	17	1	100%
15e.	Insurers compete hard to sell me employee health insurance	7	27	14	40	10	2	100%
15f.	Individuals themselves have first responsibility to see that they have health insurance coverage	29	57	7	5	1	2	100%
15g.	Health insurance costs rise (would rise) payroll costs to the point where it is (would be) difficult to compete	25	48	11	13	1	1	100%
15h.	Employers have a responsibility to provide health insurance	5	20	10	42	22	2	100%

Assuming costs cannot be split or shared, who should pay the health insurance premiums of:

		Person/ family	Person's employer	Government	NA	Total
16a.	a person working full-time whose total family income is about $25,000 a year?	60	27	6	6	100%
16b.	a person working full-time whose total family income is less than $10,000 a year?	35	29	29	7	100%
16c.	an unemployed person?	47	2	42	10	100%
16d.	the children of a person working full-time whose total family income is about $25,000 a year?	71	15	8	6	100%
16e.	a part-time worker whose total family income is less than $10,000 a year?	53	11	28	8	100%
16f.	a teenager, part-time worker, living at home whose total family income is about $25,000 a year?	83	5	6	6	100%

17. If you wanted to increase compensation for your full-time employees by $100 per month, how would you do it?

17a. If you wanted to increase compensation for your part-time employees by $50 per month how would you do it?

	(17) Full-Time	(17a) Part-Time
Provide $/mo. in wages	76	48
Provide $/mo. in health insurance benefits	11	4
Provide $/mo. in benefit(s) other than health insurance	8	3
No part-time employees	—	40
NA	5	4
TOTAL	100%	100%

18. Within the last year, has one or more employees inquired either about instituting a health insurance plan or increasing health insurance benefits under the present plan?

18a. If "yes" how did you handle the inquiries?

	(18)	(18a)
Yes, several inquiries	7	
Yes, a few inquiries	14	
Explained requests weren't currently possible		25
Generally satisfied employee requests		27
Still looking into them		19
NA		29
Total		100%
Casual references, but no inquiries	19	
No inquiries	58	
NA	3	
Total	100%	

14. Does your major competitor(s) provide employee health insurance?

Yes	32
No	20
Don't Know	42
NA	7
Total	100%

19. Do you sponsor a health insurance plan for your employees?

Yes	63
No	34
NA	2
Total	100%

19a. Estimate your cost of employee health insurance as a percent of total wages/salaries paid (Do *not* include any employee contribution.)

1%-2%	8
3%-4%	13
5%-6%	19
7%-8%	18
9%-10%	18
More than 10%	18
NA	6
Total	100%

19b. If "yes", are part-time employees usually (perhaps after a waiting period) eligible to participate in the plan?

Yes	16
No	36
No Part-Time Employees	46
NA	2
Total	100%

19bl. If "no", why do you cover full-time employees, but not part-time employees? (Mark all that apply.)

Insurance more expensive per hour of work for part-timers	29
Part-timers more often want wages than benefits	50
Higher turnover among part-timers	45
Administrative costs/hassle increase enormously	22
Part-timers easier to replace	17
Can't find insurance proportionate to the hours they work	25
Need compensation differences between full and part-timers	25
Can't afford to cover everyone; the first concern has to be my full-time employees	48
Policy doesn't allow part-timers (written)	6
Covered elsewhere (written)	12
Teen-Agers (written)	2
Other	4

19c. Are dependents of covered employees eligible?
19d. Are there employees excluded due to preexisting health conditions or older age?
19e. Are you/your family covered under the same plan as the employees?

	Dependents (19c)	Preexisting Conditions (19d)	Personal Coverage (19e)
Yes, and a supplemental plan	NA	NA	12
Yes	83	16	74
No	13	81	11
NA	4	3	3
Total	100%	100%	100%

20. Why did you institute an employee health insurance plan? (Mark all that apply.)

Employees asked for it	25
Couldn't get/keep good employees without it	31
Employees needed it	59
Union negotiated	5
A tragic event	1
Good way to cover me/my family	44
Boost employee morale	45
Cheaper than a wage increase	8
Plan in place before I took over	11
Other	5
NA	

21, 22. Suppose the cost of your health insurance plan rose __ percent within the next year, what would you do? (Mark all that apply.)

	15 Percent	30 Percent
Keep the plan I now have	44	22
Raise deductibles, raise employee share of premium, etc.	53	55
Lower plan benefits	24	30
End dependent coverage	5	8
End part-time coverage	2	2
Drop the plan	11	29
NA		
Total		

23. If you do not have an employee health insurance Plan, why don't you have one? (Mark all that apply.)

Premiums too high	65
Employee turnover too great	16
Employees generally covered under a spouse or parent's policy	43
Administrative expenses too high	17
Employees prefer cash/Lack of employee interest	34
Business insufficiently profitable	44
Profits too unstable from year to year to commit to such a fixed cost	39
Don't need insurance to attract good employees	23
Can't qualify for a group policy at group rates	22
Other (please specify)	

23a. If you can't qualify for a group policy, what is the reason?

Too new in business	5
Type of business or industry that I'm in	13
Age of employees I have	4
Health condition of employees I have	8
Other ________________	55
Don't Know	7
NA	7
Total	100%

24,
25,
26.
Suppose the government required all employers to carry a minimum amount of employee health insurance. The cost of the insurance would be about $_____ per employee (full-time and part-time of 20 hours a week or more) per month. If this were to occur, how would you respond?

	(24) $150	(25) $100	(26) $50
Purchase employee health insurance and adjust elsewhere	42	46	68
Let all employees go and continue operating	24	24	14
Get out of your business	26	22	12
NA	8	9	7
Total	100%	100%	100%

24a. If you decided to purchase insurance, how would you be most likely to make the adjustments? (Mark all that apply.)

Charge higher prices for my products/services	62
Eliminate part-time jobs	25
Eliminate full-time jobs	12
Reduce hours for some employees	29
Cut or hold-down other employee benefits	32
Cut or hold-down employee wage increases	73
Postpone or cut expenditures for plant/equipment	21
"Tighten belt" elsewhere	35
Cut or hold-down earnings	19
NA	

27. Are you/your family covered by health insurance?

Yes, individual plan	65
Yes, spouse's policy	20
No	9
NA	7
Total	100%

28. What would cause you to voluntarily provide health insurance benefits to your full-time employees? (Mark all that apply.)

Good employees became more difficult to get	23
Qualified for a group plan at group rates	27
Business became more profitable or profits became more stable	55
Insurance costs fell 20 percent	42
Fewer teenage and secondary wage-earners in my workforce	5
Employees asked for coverage	19
Had less employee turn-over	10
Had fewer part-time employees	5
Administrative costs/hassle could be cut	19
Insurance costs fell 50 percent	52
Wouldn't provide under almost any circumstances	15
NA	

1. What is your form of business?

Proprietorship	30
Partnership	7
Sub-S Corp.	15
Corporation	49
NA	
Total	100%

2. What is your major type of business activity? (If more than one, mark the one that contributes most toward your gross sales.)

Construction	15
Manufacturing and mining	14
Transportation	3
Wholesale	8
Retail	25
Agriculture	6
Financial Services	7
Professional Services	16
Professions	7
Total	100%

4. How many employees do you have, not including yourself? ________ full-time employees ________ part-time employees (= ½ full-time)

1-4	39
5-9	24
10-19	16
20-49	13
50-99	4
100 +	4
NA	
Total	100%

5. Which best describes your employee turnover?

High Turnover — (Most employees stay only a few months)	3
High Turnover — with Stable Core — (Many leave quickly, but a core stay with me)	17
Moderate Turnover — (Most employees stay a few years)	35
Little Turnover — (Rarely an employee change)	43
NA	2
Total	100%

6. Approximately what percentage of your full-time employees are "heads-of-household," i.e., the family's primary bread winner?

None	11
1-25%	14
26-50%	13
51-75%	20
76-100%	39
NA	3
Total	100%

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8. During the last calendar or fiscal year, what were your gross receipts?

Under $100,000	10
$100,000-199,999	16
$200,000-349,999	17
$350,000-749,000	19
$750,000-1,499,999	15
$1,500,000-2,999,999	10
$3 Million and Over	11
NA	2
Total	100%

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9. Which best describes your annual gross sales over the last two years?

Declined (More than 10%)	9
Declined a Bit (5-10%)	13
Stayed the Same	26
Grew (5-25%)	42
Grew Rapidly (26%)	7
Too New	2
NA	1
Total	100%

---

11. How long have you owned/operated this business?

1 Year	2
2-3 Years	9
4-5 Years	10
6-9 Years	14
10-19 Years	31
20 +	32
NA	2
Total	100%

---

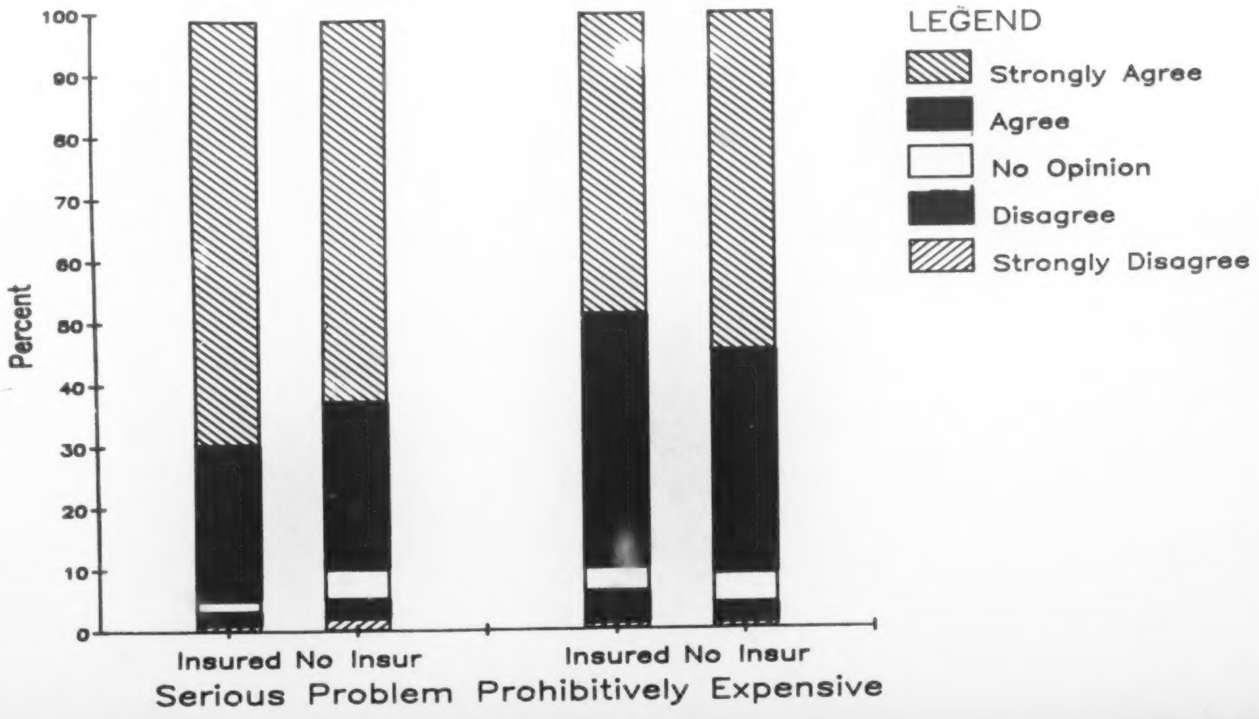
12. Which best describes the area in which your business is located?

Rural area	30
Small city or large city suburb	51
Large city	15
NA	4
Total	100%

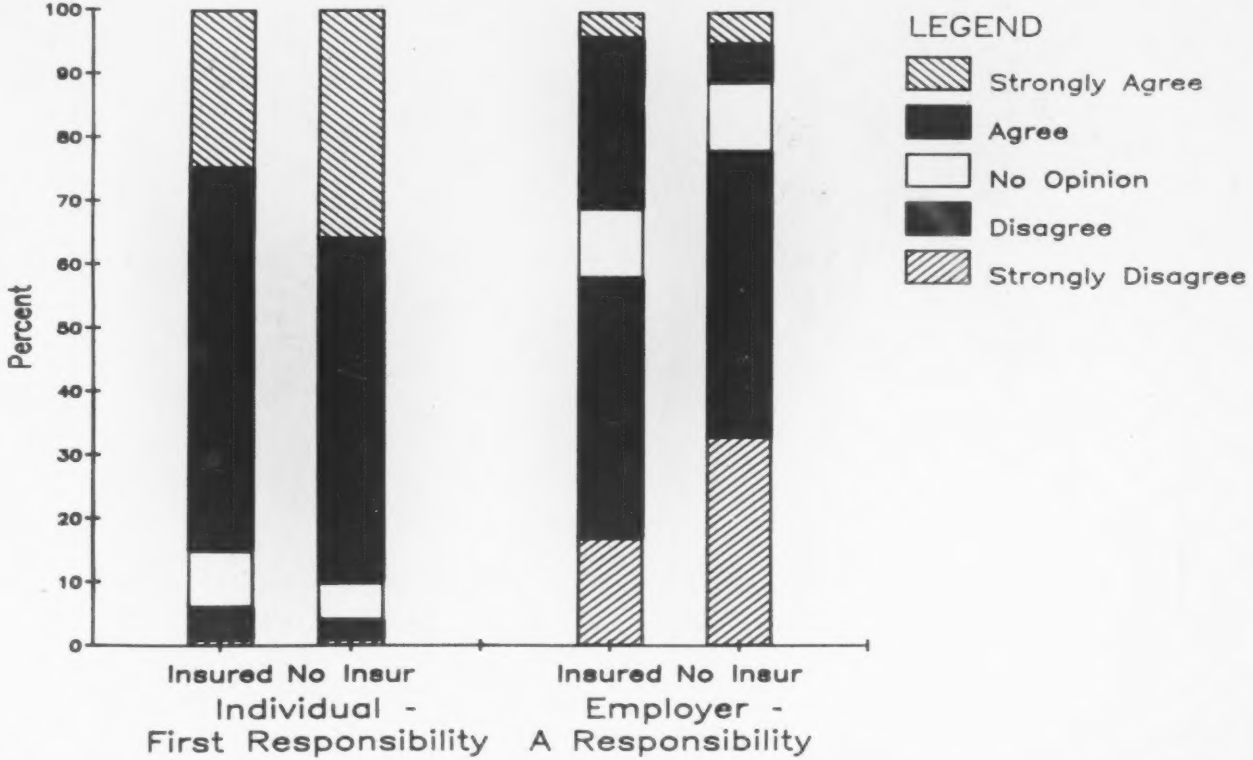
---

29. About how much did you take out (salary, draw, earnings, etc.) of the business last year?

Prefer Not to Answer	19
Under $10,000	10
$10,000-19,999	12
$20,000-29,999	16
$30,000-39,999	10
$40,000-49,999	9
$50,000-59,999	5
$60,000-69,999	3
$70,000 or more	11
NA	5
Total	100%

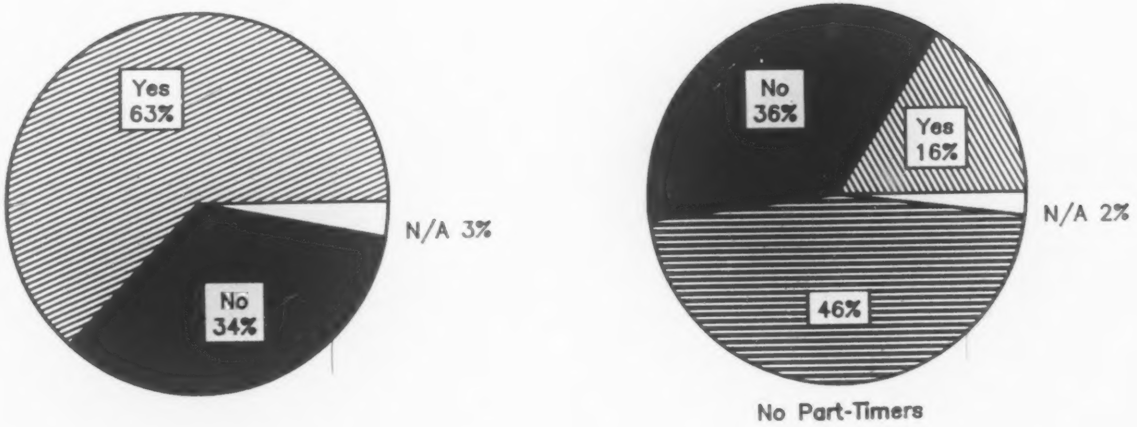


HEALTH INSURANCE COSTS A SERIOUS BUSINESS PROBLEM AND HEALTH CARE BECOMING PROHIBITIVELY EXPENSIVE - SMALL EMPLOYERS' VIEWS



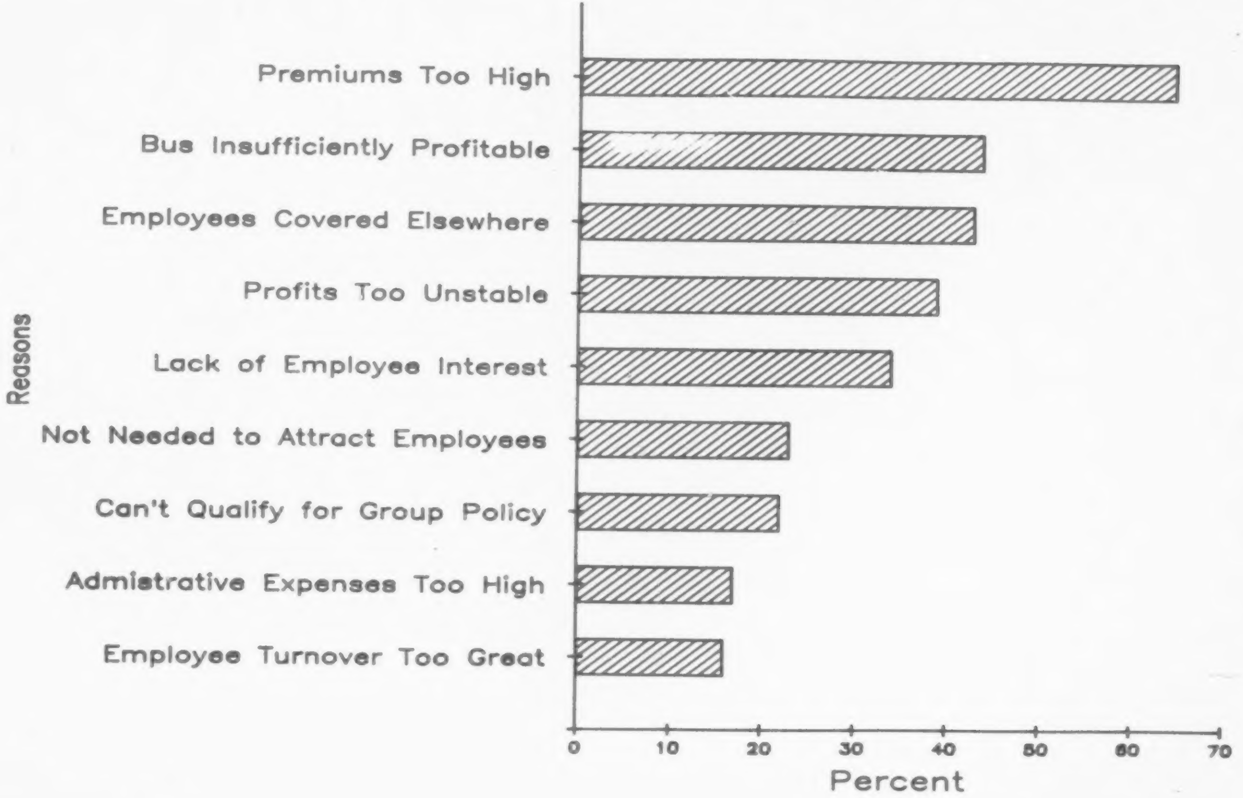
RESPONSIBILITY FOR PROVISION OF EMPLOYEE HEALTH INSURANCE - SMALL EMPLOYERS' VIEWS

SMALL BUSINESSES PROVIDING AND NOT PROVIDING EMPLOYEE HEALTH INSURANCE



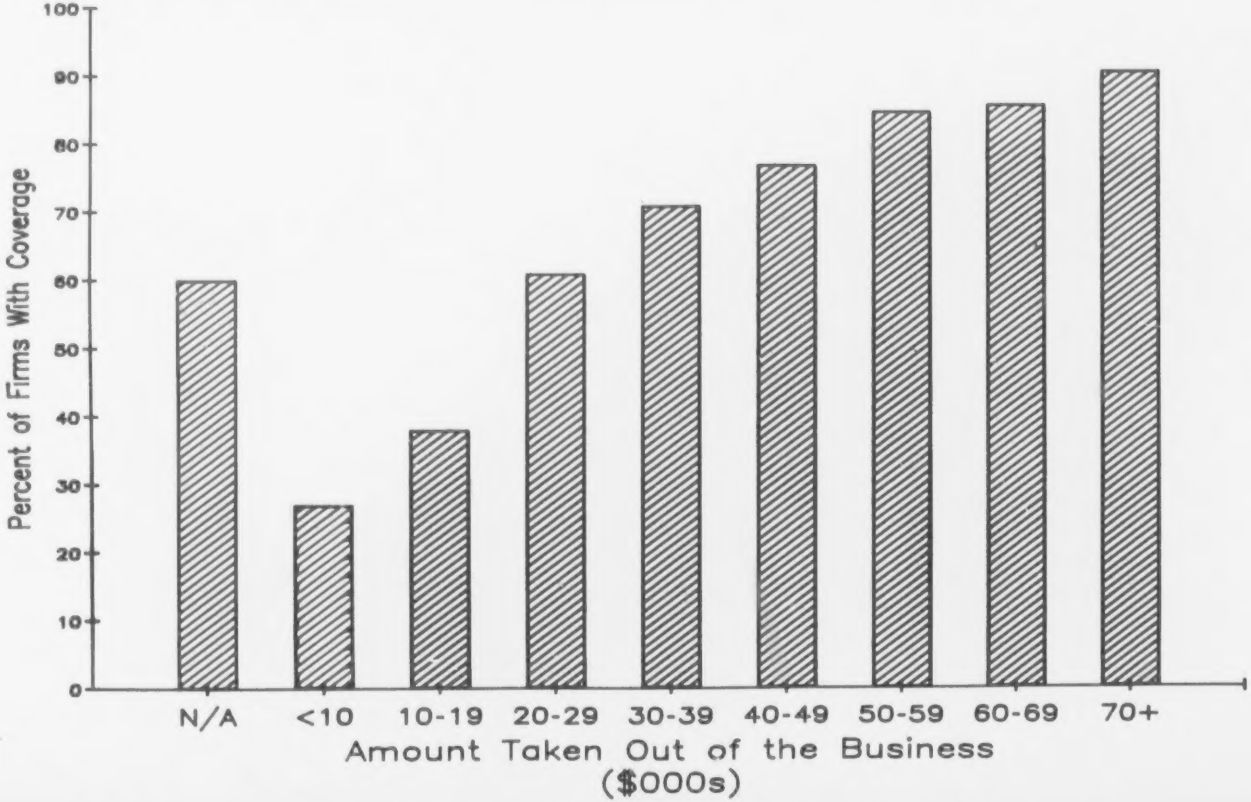
Any or All Employees

Part-Time Employees Only

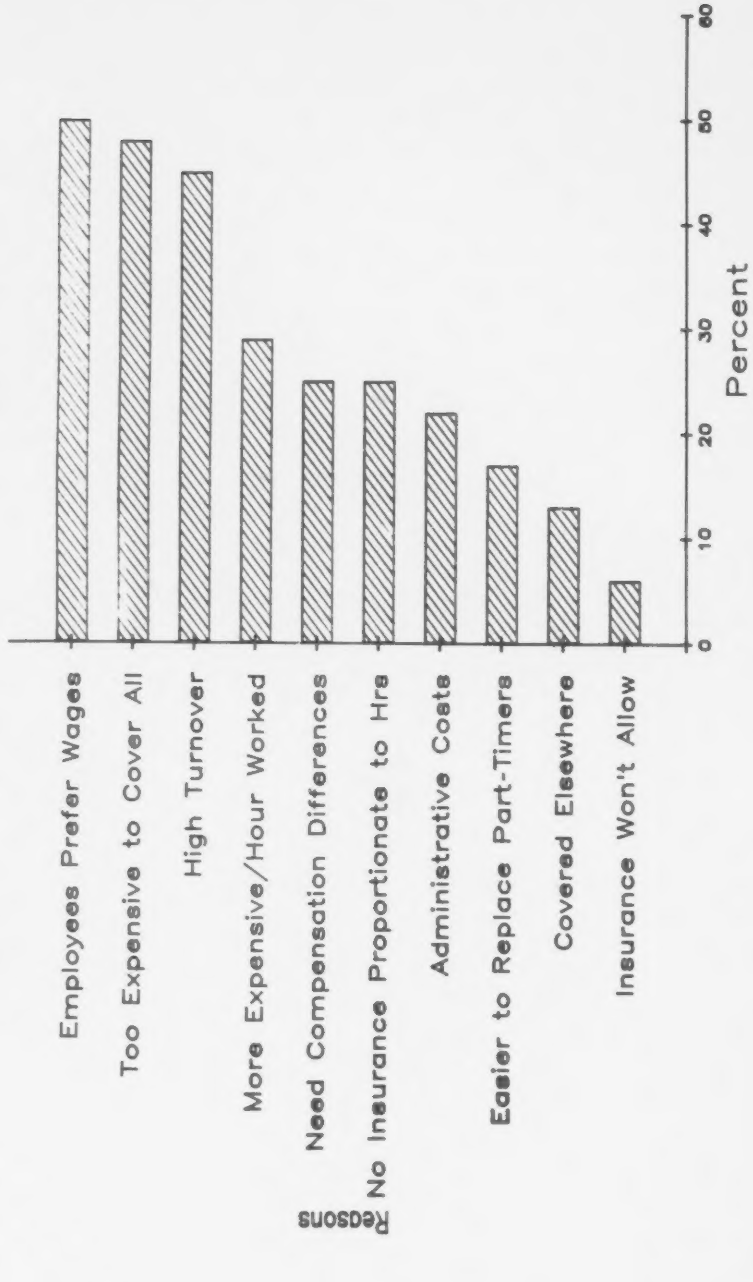


SMALL BUSINESS OWNER REASONS FOR NOT PROVIDING EMPLOYEE HEALTH INSURANCE

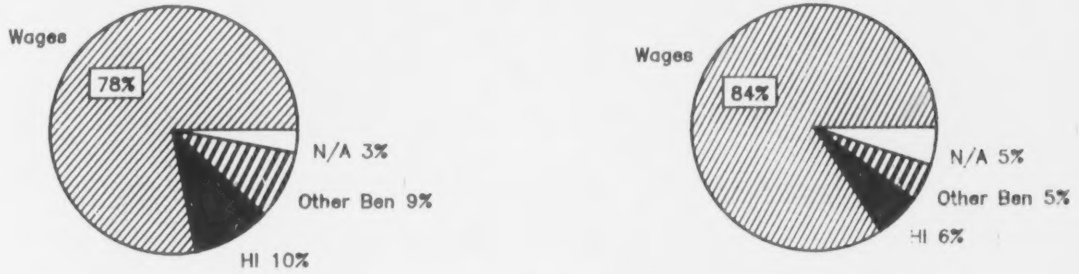
FIRMS WITH EMPLOYEE HEALTH INSURANCE
COVERAGE BY OWNER'S "TAKE-OUT"



REASONS FOR NOT COVERING PART-TIME EMPLOYEES IN BUSINESSES WITH EMPLOYEE HEALTH INSURANCE

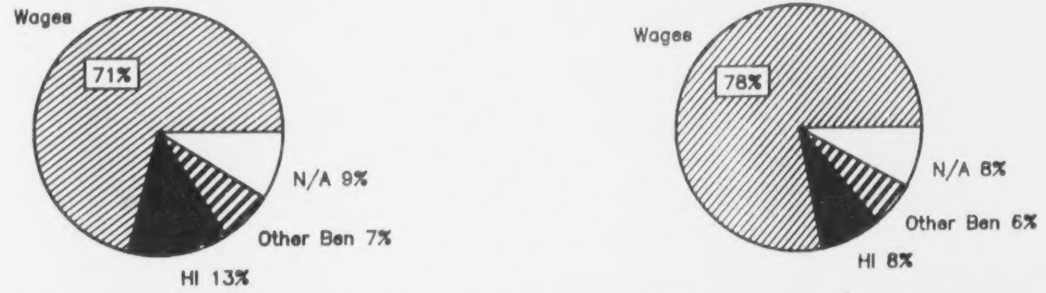


METHOD OF ALLOCATING AN ADDITIONAL $100/MO (FULL-TIME EMPLOYEE) OR $50/MO (PART-TIME EMPLOYEE) BY POSSESSION OF EMPLOYEE HEALTH INSURANCE



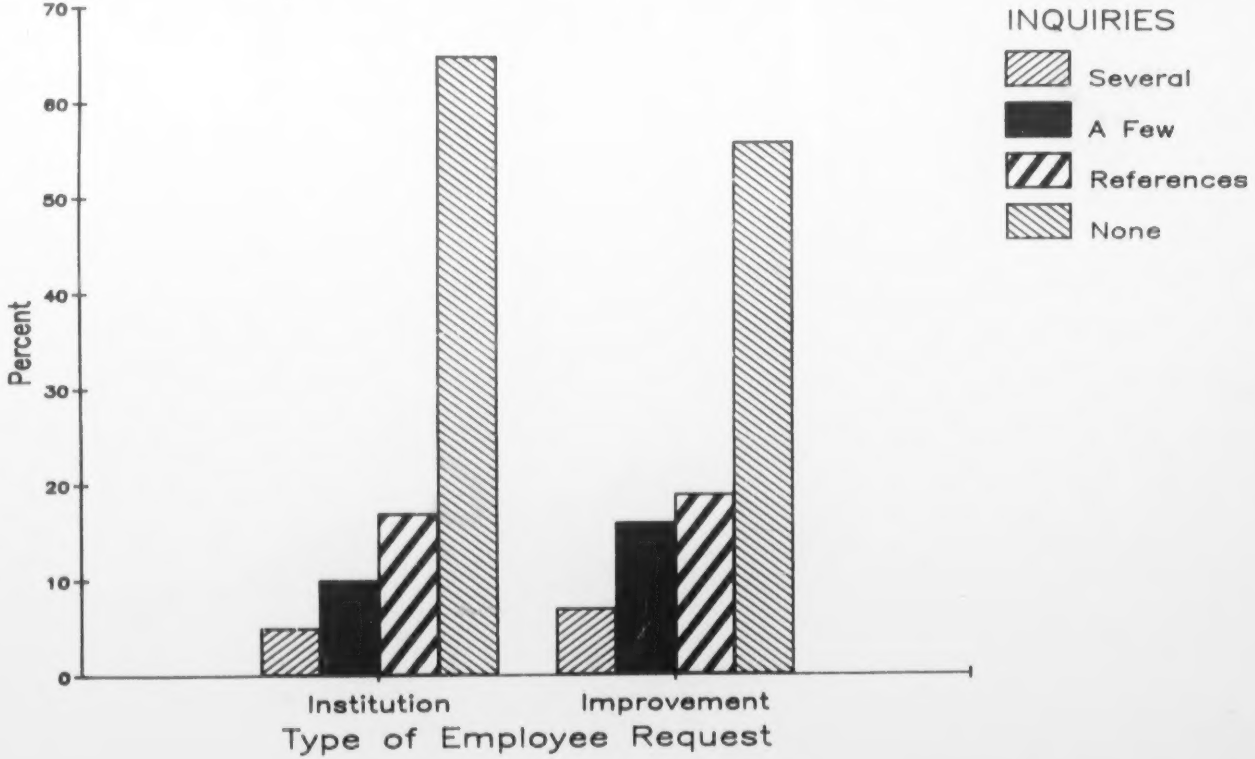
Full-Time, with Insur

Part-Time, with Insur



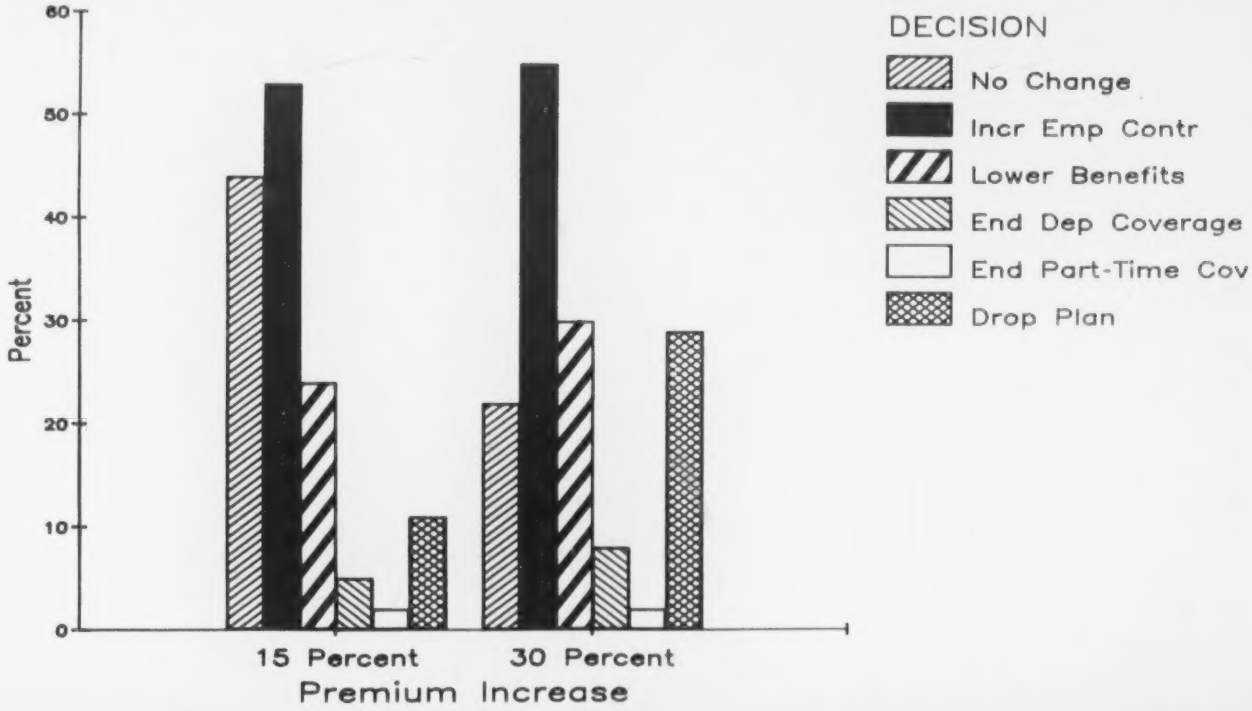
Full-Time, w/o Insur

Part-Time, w/o Insur

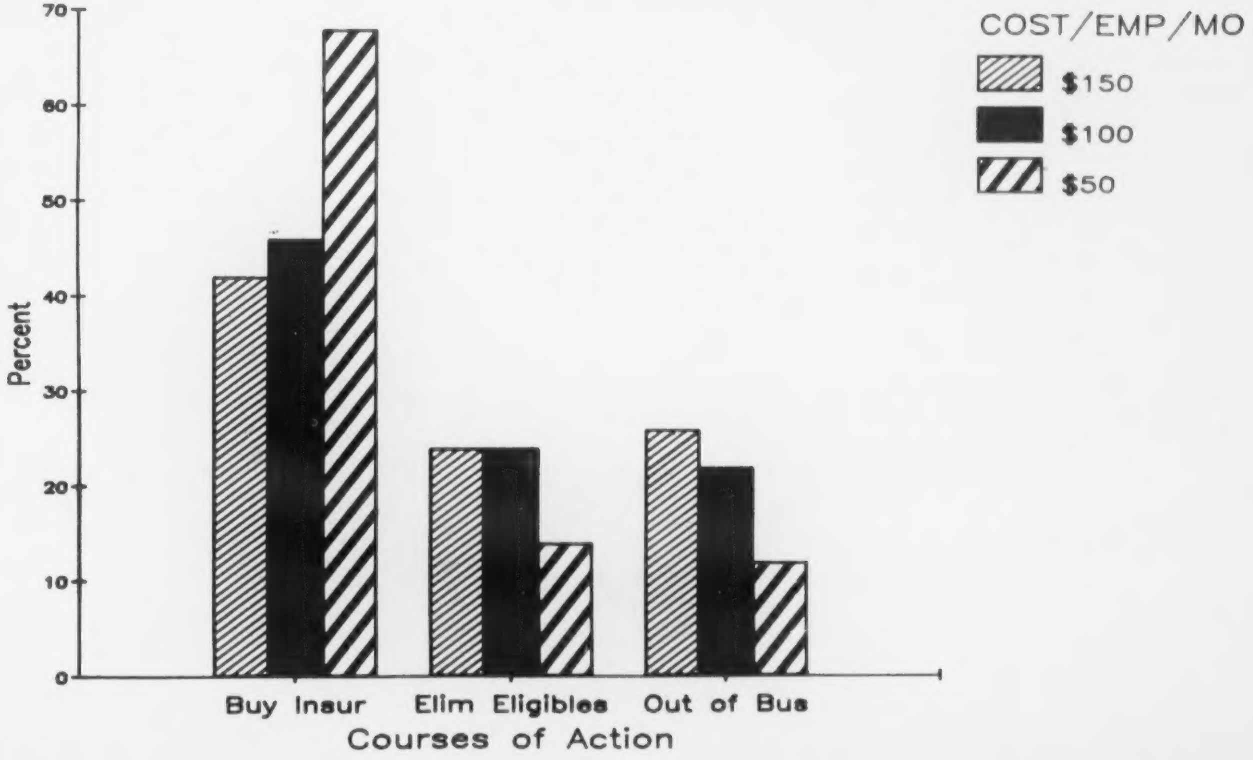


EMPLOYEE INQUIRIES IN THE LAST YEAR ABOUT INSTITUTION OR IMPROVEMENT OF AN EMPLOYEE HEALTH INSURANCE PLAN

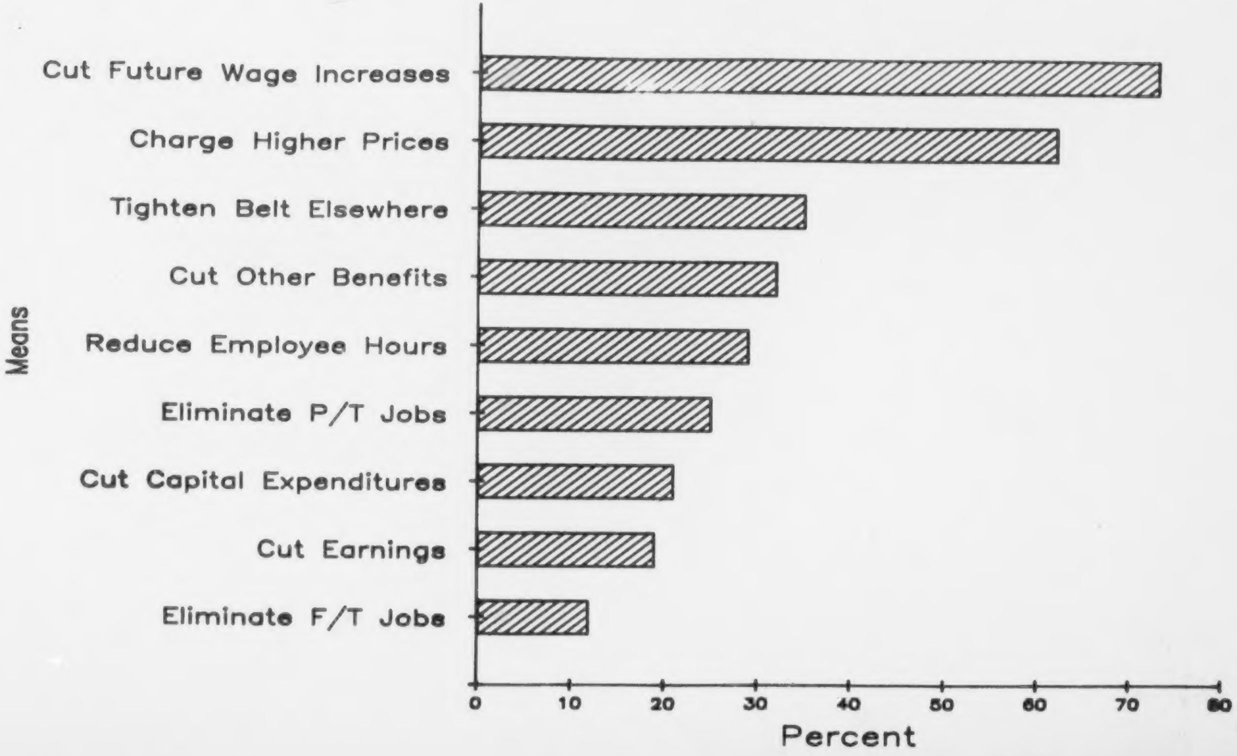
IMPACT OF A 15 PERCENT AND A 30 PERCENT INCREASE IN EMPLOYEE HEALTH INSURANCE PREMIUMS ON DECISIONS AFFECTING CONTINUATION OF THE SAME PLAN



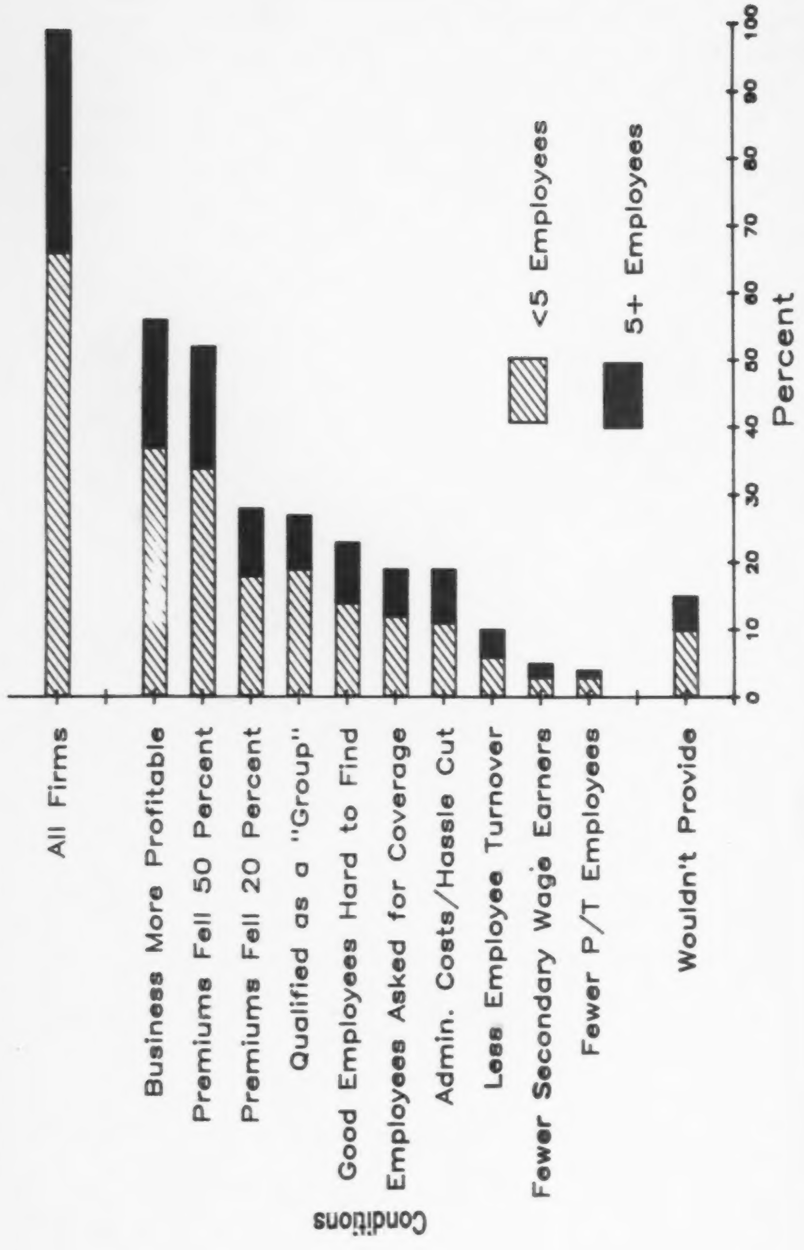
IMPACT OF SELECTED MANDATORY COVERAGE COSTS ON SMALL FIRMS WITHOUT EMPLOYEE HEALTH INSURANCE



MEANS TO COMPENSATE IF EMPLOYEE HEALTH INSURANCE EQUAL TO $150/EMPLOYEE/MONTH



CONDITIONS REQUIRED FOR VOLUNTARY PURCHASE OF EMPLOYEE HEALTH INSURANCE



Chairman ROCKEFELLER. Mr. Motley, thank you. I found your statement, which I read over the weekend, to be very, very interesting. I don't necessarily agree with everything in it, but it was an extremely carefully prepared and a well articulated paper which I appreciate very much.

Mr. MOTLEY. Thank you.

Chairman ROCKEFELLER. Mr. Burke. And Arthur Flemming is now here. Dr. Flemming, if you could come forward and after Mr. Burke perhaps you could give your testimony. We're obviously honored and delighted to have you. Mr. Burke.

STATEMENT OF THOMAS R. BURKE, A. FOSTER HIGGINS & CO., INC.

Mr. BURKE. Mr. Chairman, as stated, I'm a principle in the national health benefits consulting firm of A. Foster Higgins, but I should point out that my views don't necessarily reflect those of A. Foster Higgins.

Chairman ROCKEFELLER. That's called job security.

Mr. BURKE. Yes; that's right.

Chairman ROCKEFELLER. Indemnification. Could you bring the microphone a little bit closer?

Mr. BURKE. Yes; I welcome the opportunity to come here again before many old friends. In another life I was one of the guys that brought you the now famous or should I say infamous Medicare Catastrophic Program.

What I would like to do today is propose, in some respects, something similar to what the gentleman on my right proposed, but I have a quite different goal in mind. Whereas they would replace Medicaid with the national health system, I think there's a need to come up with a replacement for the Medicaid Program, but I also think we need to begin to get serious with systemic changes. I've been dancing with this health care cost dragon for 20 years and it seems like we keep going around and going around and don't really get to the gist of the problem. I won't recite the litany of horrors. I'm sure you've heard them many, many times.

I refer in my testimony to what I call the legacy of shame that is associated with the Federal programs that came on line in 1965 and 1966. And by that, I'm not referring to the fact that Medicare did not, in fact, enhance the well-being of America's elderly. Quite the contrary, they're much better off healthwise than they were prior to the program.

What I am concerned about, however, is the way that the Federal Government has gone around in a vacuum setting public policy, independent of the way that it has impacted on the employer community, ergo creating a large number of uninsured Americans, which I think, unless we get serious now, is going to simply increase more and more. If we had the Secretary of Defense purchasing tanks from people who were making them in their backyards, we'd take him out and shoot him. Yet we spend $50 billion in Federal entitlements for health care and we buy it from a cottage industry that we've known, since well before the Medicare Program, is about the most inefficient and most costly way to deliver health care in the United States.

I think it's time that we fess up to the grassroots problems and look at putting physicians on salary and in clinic settings where they can practice medicine efficiently and eliminate many of the scandalous markups that exist. Many of these markups are needed in hospitals to justify paying for the care of uninsured. We have sort of a vicious cycle. The markups in the hospitals; for example, a $40 x ray, done in a clinic would cost $2.50 for the film. Hospitals need to charge $40 because they've got a lot of people who can't pay and the fact that it's $40 is the reason why a lot of people can't pay.

So; I think we need to bring employers, small business, Medicaid, Medicare buy-ins, and just simply unemployed individuals, together into a program that's going to provide health care in an efficient, cost-effective, sensible way. We have over 20 years of experience where we have tried to put Band-Aids and artificial caps on the health cost spiral and, in every instance, physicians have been able to game any system that the Federal Government has devised and game it quite well.

We're plagued each year with 16.5 percent increases in the payouts. In years when I was in HHS when we gave the physicians a zero increase in their rates, yet payments in Medicare part B went up at a 16.5 percent rate. How do you think the small businessman feels when last year he was experiencing a 29.6 percent or greater increase in his health care costs? A person doesn't need to be a rocket scientist to sit down at a desk calculator and realize at a 30 percent rate of increase, it's not going to be long before health care costs are a bigger cost to the employer than payroll.

I think this can be fixed. I think this can be fixed by the Government first considering the impacts of its Federal policies. The initiatives that are on the shelf right now, such as expenditure targets, resource base, relative value systems, overpriced procedures, all of these things are going to cause whiplash effects on the employer community. The physicians will simply shift the cost to the private sector.

I've laid out a proposal that would bring these groups together, provide care in efficient clinic settings with the assistance of Federal incentives, through an increased Medicaid matching, and would establish efficient delivery systems where we could get much more care per dollar spent, treat many more people, reduce the ranks of the uninsured, and provide an access for those small employers who can't now find affordable insurance.

We have 12 million children in the United States that have no health insurance. I think that's disgraceful. But I also think the fact that we have continued to buy our health care from this cottage industry without demanding that it become efficient. By not providing incentives to efficiency in the delivery of health care, the Federal Government has got to take some of the blame for the current crisis we face. The Federal Government must now take the initiative in correcting the situation. Thank you.

[The prepared statement of Mr. Burke follows:]

A PROPOSAL TO PROVIDE AND IMPROVE ACCESS TO AFFORDABLE AND ACCESSIBLE HEALTH CARE TO ALL AMERICANS

A STATEMENT BY

THOMAS R. BURKE, PRINCIPAL
A. FOSTER HIGGINS & CO., INC.

BEFORE THE
UNITED STATES BIPARTISAN COMMISSION ON
COMPREHENSIVE HEALTH CARE

OCTOBER 24, 1989

Chairman Rockefeller and Members of the Bi-Partisan Commission:

I am Thomas R. Burke and I am a Principal in the National Health Care Practice of A. Foster Higgins & Co., Inc., a national benefits consulting firm.

In another life, I was co-author of the "Bowen-Burke" catastrophic health care proposal, which led to the Reagan Administration's Medicare catastrophic legislation. While it is certainly unusual not to have Dr. Bowen sitting next to me to deflect hard questions, let me assure you he is enjoying his well-deserved retirement!

I welcome the opportunity to come before many old friends and share with you my views on the critical issues of health care affordability and access in America. I trust you will find my testimony to be provocative and my recommendations worthy of your serious consideration. With your permission, I shall summarize my written statement. I will initially summarize what I see as the failings of the traditional Medicare and fee-for-service systems, and then offer a proposal I have developed for a public/private sector initiative to address these shortcomings.

A LEGACY OF SHAME?

If our sole intent in enacting Medicare 24 years ago was to direct Federal resources toward improving the health care of the aged and disabled, we've left a legacy of shame. While this program provides insurance that the elderly, often frail, Americans throughout the country will receive health care, it also provides insurance that physicians will be paid. The impact of this program, ironically, so aggressively opposed by the medical profession, has been to provide a federal guarantee that physicians will be reimbursed for most of the health care they provide to America's aged and disabled.

The shameful legacy of Medicare is that health care in America has now become a big time business to the detriment of those who need it most. Health care is either the second or third largest industry in the United States, depending on whose statistics you care to use. A perception has developed within America that being a physician equates with a large income. This may sound like a very calloused statement but let's look at some of the facts.

One baby in four born in the United States today is delivered by cesarean section. A recent University of California at Berkeley study showed that pregnant women with an income above $30,000 are almost twice as likely to have a C-section than women with an income below $11,000. C-sections are one of the fastest growing procedures in the United States, yet very few are performed on Medicaid recipients. This, no doubt, is due to the fact that they are much healthier than women who can afford Blue Cross coverage! I, for one, have warned my daughter not to accept too high a salary when she gets out of college and is at the child bearing age, since this would undoubtedly shrink her birth canal and she'd have to have her children by C-section! House calls, by physicians, are almost non-existent. Why? They don't make money, and the Inspector General of the Dept. of Health and Human Services recently reported that patients visiting physicians with a financial interest in medical laboratories are tested 38% more than those patients using physicians without such a financial interest.

As further proof of this historical trend, examine the economic stabilization program in place from August 1971 thru April 1974. Strict limits were placed on physicians fees during this period limiting them to only a 2.5% increase per year. Any increases also had to be cost justified. During this entire period, no physicians sought exceptions to the stabilization program regulations, however, payments to physicians during this period increased each year at double digits.

We've known since then that controlling physician prices does little to restrain the cost of physician care. While we have this knowledge, little effective action has been taken. In 1986, approved Medicare charges for tests conducted in independent and physicians' office labs amounted to just under $1 billion--a 20% increase over 1985. During that year, both the population and fee schedule rates rose by only 2%. Thus, approximately 80% of the rapid increase in laboratory testing under Medicare resulted from an increase in the number of services provided per enrollee.

What is true for physicians is also true for other health care providers. It's been estimated that between 1/4 to 1/3 of the medical procedures performed in the United States are unnecessary and wasteful, costing the Nation $150 billion in 1988. Yet, we allow the health care industry to gobble more and more of our resources and we approach the issue with piecemeal, band-aid solutions. In 1983, we enacted prospective payment to get a better handle on the costs of hospital care in America. In a very real sense, this program has been very successful for the public sector (Medicare). In another respect, however, it has simply transferred costs to other settings and to other payers, thereby making health care less affordable to other segments of the American population.

From 1981 to 1987, costs per outpatient visit increased 88% and the number of outpatient visits per 1000 persons covered increased 26%. Inpatient days for this same period fell 26%, whereas the cost per inpatient case rose 77%. Outpatient costs can now range up to 80% to 90% of inpatient costs. Twenty percent (20%) of hospital revenues now come from outpatient care. What this seems to indicate is that, as the Medicare program has racheted down on inpatient Part A costs, physicians have been quick to move workload to an outpatient setting where they can still be reimbursed on a cost basis.

Even on the hospital side, the effectiveness of cost containment measures leaves something to be desired. After prospective payment was enacted, hospital admissions fell 3.3%, inpatient days fell 7.8%, however, total hospital personnel fell only 1%. On a percentage basis, therefore, hospital staff actually increased 7.4%. The decline in hospital lengths of stay and admissions was actually accompanied by an increase in the cost per day sufficient to enable hospitals to actually increase their operating margins at reduced levels of capacity utilization. There are very few other industries in the United States that are capable of accomplishing such a feat!

We have known, since enactment of the Medicare program, how inefficient and wasteful the provision of care in the fee-for-service sector is. I reference the following quote by the first Administrator of the New York Health Services Administration that is extracted from a March 1968 issue of the journal Inquiry,

> "But even if all the activities both in and out of government during the past 35 years had been successful in reaching their population, our problem would still not have been solved because all of these programs assume the sanctity of the piecework, fee-for-service system and have failed to recognize that this is the most costly and inefficient way to finance health care. We have, therefore, thus far failed to secure one major determinant of a health care system--a rational method of financing. The second determinant of a health care system is the organization of services. As early as 1930, or thereabouts, there was a general recognition that the solo practice system of medical practice did not lend itself to the most efficient utilization of health manpower and health dollars. In the early 30's, such health care economists as Michael Davis and Franz Goldmann advocated the reorganization of health care delivery and proposed group practice as one approach to such reorganization. They simultaneously proposed prepayment as the financing mechanism recognizing that one without the other would not have the maximum effect in creating a meaningful system."

CONSEQUENCES

What I am saying is not new, startling or revolutionary. We have known for years that reimbursement drives the system. What we haven't realized, apparently, is how far it has driven the system and how awesome the consequences have been. Left to their own devices, physicians act as prudent businessmen and are capable of using any reimbursement system which has, as its underpinning, a set of incentives that are less than neutral.

The biggest consequence of government reimbursement practices, as I see it, is the enormous annual cost increases that self-insured, large employers and others are made to absorb. They have neither the market power nor the expertise in most instances to control the costs that are shifted to them as a result of Federal initiatives.

The record of the last decade has been that the consequence of providing health care to the elderly through the Medicare program has been to deny health insurance coverage to many other Americans under 65. As a result, the number of uninsured, and underinsured Americans has grown dramatically in recent years. A not insignificant portion of this phenomenon must be attributed to the fact that health care is no longer affordable for many Americans. Access to health care is a function of its affordability. Whereas, we as a nation spend a larger percentage of our GNP on health care than any other industrialized nation in the world, we also have the largest segment of uninsured and under-insured Americans who receive limited or no health care. Regrettably, this includes a large number of children in the United States. The Medicare program that was intended to help the elderly, many of whom were among the poorest of Americans when it was enacted, has led to a vast improvement in the status of elderly Americans but this improvement has not been without its cost. For every elderly American in poverty today in America there are six children in poverty, many of whom receive limited or no health care coverage. It is those children who are just above the poverty level who suffer perhaps even more in that they are not entitled to obtain health care through the Medicaid Program.

One might wonder how much longer Washington will myopically guard the Medicare budget at the expense of all other purchasers of health care? When are we going to approach this problem in a systematic way that is effective in its outcome? We cannot remove perverse incentives in the hospital industry and at the same time expect the perverse incentives in other payment modalities in health delivery settings not to be exacerbated. What I am advocating is not a national insurance scheme, nor an all-payer federal system. Quite the contrary, I am calling for the Federal Government, and this Commission specifically, to look at actions that can be taken to address the health care problem systemically. We still have perverse incentives in physician reimbursement. We've seen the shift to outpatient settings, the growth of surgery centers and in-office provision of expensive diagnostic procedures and tests. This would not be possible nor likely to result were we to remove all perverse incentives. In settings where these perverse incentives do not exist, such as group and staff model HMOs, we have not observed this phenomenon. Where we have removed the financial incentives for physicians and providers to undertake procedures to enhance their incomes, we have seen rates of utilization of only half of those that we have seen in the fee-for-service sector.

It would seem, that we, as a nation, have tried the piecemeal approach. It hasn't worked. We ought to be now willing to address systemic reform of the health care delivery system. Admittedly, this is not going to be easy, painless nor quick, but current conditions warrant that it begin now.

ROLE FOR THE FEDERAL GOVERNMENT

Before we race down the well-worn road to national health insurance, let's first try to take action at the Federal level that will stimulate changes toward more efficient health care delivery systems in America. Why not reward delivery systems that contain no perverse incentives to encourage practicing inefficient, costly medicine? I urge the Commission to look at tax preferences and other steps that would encourage the proliferation of these kinds of delivery systems while simultaneously providing incentives for Americans to use them. This is achievable and certainly deserves to be tested first before we consider a nationalized system.

Federal actions now being considered for Medicare--expenditure targets, resource based relative value systems, or reductions in payments for over-priced procedures--will surely have a whiplash effect on other payers, such as corporate America, who have not the knowledge nor the purchasing clout that is exercised by Medicare. I have been surprised and alarmed at the level of naivete regarding health care that exists in corporate America. Many corporate managers believe they have tried every possible solution to no avail. This, unfortunately is not the case: what they have tried is every alternative that's a creation of the medical and health insurance industry. Time after time I have heard executives of large corporations say, ..."but I'm in the manufacturing or production of x commodity and not in the health care business...". Yet, in the next breath, they'll complain that they have trouble competing internationally because of their health care costs and their mounting retiree health care liabilities. Annual costs in excess of $3,000 per employee are not at all atypical for American business. What's even more alarming is the 30% annual rate of increase in health care costs being experienced in corporate America. One needn't be a rocket scientist to realize that, compounding at this rate, we'll soon make health care costs a bigger cost to corporate America than payroll. It's incumbent upon the Federal Government when devising or implementing stringent, prescriptive policies for public sector programs to note the impact of these policies on the private sector and the probable consequences they can have on corporate America. At the very least, actions should be taken in the public sector that are going to foster efficient delivery systems that corporate America and other private payers can utilize.

Since the Federal Government played a key role in creating the health care cost and access dilemma that we now face, the Federal Government must take the initiative and play a role in helping solve the problem that it helped to create. Let me again quote Dr. Houghton:

> "Clearly, government must take the initiative and provide the leadership in dealing with the issues which are determinants of a meaningful system. It has been suggested that if all biomolecular research should be suspended for the next ten years, and all our research efforts, both human and financial, turn to operational research aimed at bridging the gap between our knowledge and our delivery of services, we would more than likely save more lives and have much greater impact upon the health status of the nation than would be possible as a result of further medical research.

Considering the circumstances in which the United States now finds itself; that is, we spend more than any other nation in the world on health care yet still have some 37 million uninsured...we have the highest infant mortality rate in the industrialized world...this statement of more than two decades ago could almost be considered prophetic.

SOME WORTHWHILE LESSONS FROM THE PRIVATE SECTOR

Some large corporations in the United States, previously hemorrhaging from health care costs, have taken actions that might well be emulated by the public sector. These effective corporate actions represent what I consider to be a proposal for rational reform of the health care system which is short of a national health insurance scheme. The innovative corporate programs that have been undertaken at companies such as, Goodyear, Gillette, Southern California Edison and others should be adopted or tested in the public sector so as to increase access to health care by making it affordable to those who cannot afford it under existing conditions. In particular, it's America's small employers, that represent the vast majority of the corporations of America, which are being unduly penalized by the ever-escalating health care costs and which could benefit from this approach. They either cannot afford to provide health insurance to their employees, or if they can, they pay incredible amounts for this benefit. This need not be the case.

HOW TO PROVIDE ACCESSIBLE HEALTH CARE IN THE UNITED STATES

A number of large corporations in the United States have undertaken initiatives that are saving them considerable amounts in their health care expenses without sacrificing the quality of care provided to active employees and retirees. The thread common to all of these initiatives is that increasingly corporations are hiring physicians to provide at least primary care services to their beneficiaries. Some companies, such as Gillette Corporation, have had such arrangements in place for a number of years, and others are about to embark on similar ventures.

The use of salaried physicians has been commonplace in U.S. group and staff model HMOs for many years; the savings that these delivery systems have furnished their members over the years vis-a-vis fee-for-service practices has been substantial. Utilization of inpatient hospital services by HMO enrollees has traditionally been significantly lower than in the fee-for-service sector and studies which have been undertaken show no diminution in the quality of care provided.

The record of group and staff model HMOs over the years, as well as the efforts that are currently getting underway in corporate America hold forth, I think, a lesson for providing efficient, effective health care to America's uninsured.

As noted earlier, employers that seem to be most adversely impacted by high health care costs are small employers, which account for most of the employment in the United States. Twenty-two million of the estimated 37 million uninsured are employed full-time, yet do not have health insurance. These are the American workers who must confront each day, the terrible apprehension and fear that they or one of their loved ones may become seriously ill.

This number of uninsured could probably be greatly reduced if a private, public sector initiative were undertaken in each state whereby a business/government entity would be established to provide health care. This system might be patterned along the following lines. A business organization, whether it be a state chapter of the Chamber of Commerce, a multiple employer trust, or a business coalition of small employers, could band together with the appropriate state agency to set-up a network of primary care clinics throughout the state. These clinics would be staffed by salaried physicians who would be employees of this private/public sector entity. There would be a board of directors, from which the business community would appoint three members, the Governor would appoint three members and a chairman would be selected who is mutually agreeable to both groups. The board would oversee the operations of the public/private sector entity.

Small business would be given the option of buying into, for a defined premium, the health insurance benefit package offered by this entity. The benefit package could be restricted so as to limit the premium burden on small employers. It could emphasize primary care and preventive care, as well as necessary inpatient care and perhaps drugs. At the start, the benefit package need not be significantly different from the mandatory benefits that each state is now required to offer to its Medicaid population. Drug costs could be minimized through statewide wholesale purchasing, use of formularies and other available methods.

The state could use this network of clinics to provide care to its Medicaid-eligible population as well as the elderly population for which they buy into the Medicare program. The state would pay a premium similar to that of the small employers for the care furnished to Medicaid recipients. The state could, uncouple Medicaid eligibility requirements from AFDC standards and raise its Medicaid-eligibility income level although this would require either legislation or a waiver. This would increase the number of people (and the income level of people) eligible for Medicaid participation. That is, the AFDC eligibility level could be left in place, and the Medicaid eligibility level, as measured by the percentage of poverty level required for eligibility, could be increased. This would bring more of the near-poor into the health care system for which the state could buy-into, on a premium basis, the private/public sector entity health care delivery system.

State costs for Medicaid eligible people brought into the entity for care, could be matched at a greater federal matching rate. This is not unprecedented since, when the Medicaid management information system requirements were levied on states, the Federal matching for these expenses, remained at 90% for several years. If the state expanded the facilities needed to provide primary care clinics throughout the state, these expenses could be underwritten by the federal government in total by means of an increased Medicaid matching rate for these earmarked expenses. The small businesses would not be charged a premium for the capital equipment expenses associated with setting up clinics throughout the state.

Clinics could be established in schools that are closed or under utilized and it's conceivable that the capital expenses could be kept to a minimum. The clinics would be dispersed throughout the state and would be available to small business employees, Medicaid-eligibles, those additional Medicaid eligibles who would be just above the poverty line and the elderly Medicare buy-ins. Individuals who are unemployed could also buy-in to the system for a defined premium which would be less than is otherwise available commercially because of the restricted benefit package provided and the more efficient delivery system.

Finally, stop/loss features could be embodied into the program to safeguard against unanticipated, very high cost episodes of illness. This stop/loss could be obtained commercially, perhaps off-shore, or if unavailable commercially, through a statewide risk pool arrangement. The cost of this stop/loss feature would, no doubt, be more than offset by the cost avoidance from reduced bad debt experiences. To the extent that hospital bad debt expenses were reduced by this system, they could be asked to contribute for the cost of establishing and maintaining either commercial stop/loss or state risk pool arrangements. As this system grew within a state, with more and more of the population opting into it to obtain their health care, the entity could expand the number of services provided in the clinics. They could expand the benefit package to include those benefits that are now optional under the Medicaid program. On-site dental programs, ophthalmology, and others could be provided in the clinic. In addition, if the workload were to demand it, the entity could hire a full-time Ob Gyn staff to provide these types of services as well.

Even for those services that were not offered in the clinics, but would be necessary in connection with a hospitalization, a true preferred provider network could be set up by the clinics within a metropolitan area and preferential rates obtained for the entities beneficiaries. The growth of the number of beneficiaries using the private/public sector entity for its health care would also enable the entity to bargain effectively with inpatient facilities for preferential rates.

Such a system would afford small employers what they do not now have: affordable health care and the ability to exert leverage on providers of health care. The state beneficiaries, above the poverty level, using the system could be charged an income related premium to defray part of the cost for using the system. Because they were low income beneficiaries the income related premium would not likely be greeted with the same enthusiasm as it was in the Medicare Catastrophic program!

Over a longer term, states could provide scholarships to needy college graduates seeking to enter medical school in exchange for commitment from these students that they would serve x-number of years in the primary care clinics. This is not altogether different from what the military and the public health service now do through their scholarship programs. Because the clinics would more often than not be located in large metropolitan areas, their attractiveness would be greater than current, existing federal scholarship programs which often require medical graduates to serve on remote Indian reservations and other less desirable sites.

CONCLUSION

The above is a framework which can be refined with the scrutiny of many minds. It would take a giant step toward reducing inefficient delivery systems which have grown and prospered as a result of the Federal programs which have been initiated in the last few decades. By fostering more efficient delivery systems, states could take a giant step toward reducing the number of medically uninsured within their state. State programs could be tailored to local conditions and the Federal Government could exercise an oversight capability much as it does with the Medicaid program today. Most importantly, however, this would offer a source of affordable health care to the millions employees of small companies who now lack any health insurance because of its excessive and prohibitive pricetag. Finally, such a program would remove much of the social stigma that accompanies individuals who must obtain health care and are unable to pay for it. Frequently, they obtain necessary health services through the most expensive settings--(i.e., emergency rooms).

Winston Churchill once remarked that Americans can be counted upon to do the right thing but not until they've tried every other alternative. This quote seems very apt to where we are in the health care dilemma today in America.

I thank the Commission for giving me this opportunity to share my ideas.

Chairman ROCKEFELLER. Thank you, sir, very much. Dr. Flemming, we're glad you're here, sir, and we welcome your testimony.

STATEMENT OF DR. ARTHUR S. FLEMMING, CHAIRMAN, NATIONAL HEALTH CARE CAMPAIGN

Dr. FLEMMING. Thank you very much, Mr. Chairman. I am grateful for the opportunity of appearing before the Commission. I appreciate your working me in after the time I was scheduled, but I had made a long-term commitment to appear before a committee on long-term care of the Assembly of the Commonwealth of Virginia this morning and I appreciate your enabling me to fulfill that commitment.

The people of this Nation are deeply concerned about the negative impact of our present patchwork health care system. This concern is reflected in polls on health care. It is reflected in testimony, I'm sure, presented to the members of this Commission.

The American people are calling for the replacement of our patchwork health care system with a national health plan, a plan that will provide universal access without discrimination, to adequate health care, including long-term care; will provide a high quality of care; and will provide for cost containment. A very high percentage of persons polled on the need for such a plan have voted affirmatively. The percentage of support drops, but not markedly, when persons polled are reminded that a national health plan will require additional taxes.

We have demonstrated that we have the will and the capability as a national community to pool our resources through payroll contribution in order to make it possible for our people, wherever they may live, to have the benefits of a family income insurance program. Our Social Security Program has enabled millions of families to deal with the hazards and vicissitudes of life, to quote the late President Roosevelt: "growing out of loss of income because of retirement or the death or disability of the person on whom the family has depended for income." We can and we must pool our resources as a national community in order to deal with the hazards and vicissitudes that confront tens of millions of our people who are falling between the gaps in our health care system.

It was this need that brought into existence 4 years ago the National Health Care Campaign, a coalition of over 130 national groups and 36 State coalitions. We have only one goal; namely, the enactment of legislation which will provide us with a national health plan. We believe it is morally and ethically wrong to deny more than 30 million of our people access to any kind of care and to deny a very large percentage of our total population access to long-term care.

We believe it is fiscally irresponsible for our Nation not to have a national health plan. We are confronted with uncontrollable spiraling health care costs. The experience of other industrialized nations demonstrates that it is impossible to introduce effective cost containment in the health care field without having a national health plan. Therefore, a failure to enact and implement a national health plan is fiscally irresponsible from the standpoint of Federal, State, and local budgets; budgets of private sector organizations; and above all the budgets of consumers.

We believe we have the capacity and the will as a Nation to finance a national health plan. Studies show that there will be savings, in both the public and private sectors in administrative costs, if we initiate a national health plan. Nevertheless, there will have to be an infusion of additional public and private resources. One estimate, based on a plan presented to your committee, would call for a 5-percent increase in our $600 billion health care bill. We believe a financing package, based on social insurance principles, can be developed and will be supported if the American people are assured that the revenues raised by the package will be used exclusively for health care.

We welcome the establishment of the Pepper Commission. We regard it as a window of opportunity. We welcome especially the fact that on or before March 1, 1990, this Commission will make, to quote from the law establishing the Commission: "specific recommendations to the Congress respecting Federal programs, policies, and financing needed to assure the availability of comprehensive health care services for all individuals in the United States."

We are confident that your recommendations on programs, policies, and financing will add up to an action program designed to make it possible for us to join all the other industrialized nations of the world, except South Africa, in recognizing and implementing the right of access to health care. Once your report is filed I believe that the action program will be supported by the broadest based coalition that has supported any social program in the last 50 years. The people are ready for and want action. Thank you, Mr. Chairman.

[The prepared statement of Dr. Flemming follows:]

OUTLINE OF TESTIMONY

BY

ARTHUR S. FLEMMING
CHAIRMAN, NATIONAL HEALTH CARE CAMPAIGN

BEFORE THE
PEPPER COMMISSION ON HEALTH CARE

October 24, 1989

I. Introduction

- A. I am grateful for the opportunity of appearing before the members of the U. S. Bi-partisan Commission on Health Care--now known as the Pepper Commission.
- B. The people of this nation are deeply concerned about the negative impacts of our present patch-work health care system.
  - 1. This concern is reflected in polls on health care.
  - 2. It is reflected in testimony presented to the members of this Commission.
- C. The American people are calling for the replacement of our patch-work health care system with a national health plan--a plan that--
  - -- will provide universal access, without discrimination. to adequate health care, including long term care,
  - -- will provide a high quality of care, and
  - -- will provide for cost containment.
  - 1. A very high percentage of persons polled on the need for such a plan have voted affirmatively.
  - 2. The percentage of support drops--but not markedly--when persons polled are reminded that a national health plan will require additional taxes.

II. Body

- A. We have demonstrated that we have the will and the capability as a national community to pool our resources, through payroll contributions, in order to make it possible for our people, wherever they may live, to have the benefits of a family income insurance program.

1. Our Social Security program has enabled millions of families to deal with the "hazards and vicissitudes of life" growing out of loss of income because of retirement or the death or disability of the person on whom the family has depended for income.
2. This accomplishment is a clear indication of what can be done to replace our present patch-work health care system.

B. We can and we must pool our resources as a national community in order to deal with the hazards and vicissitudes that confront tens of millions of our people who are falling between the gaps in our health care system.

1. It was this need that brought into existence four years ago the National Health Care Campaign--a coalition of over 130 national groups and 36 state coalitions which represent older persons, children, labor, health care providers, disability groups, mental health groups, consumer, religious and civil rights organizations.
2. We have one objective, namely, the enactment of legislation which will provide us with a national health plan that will provide universal access, without discrimination, to adequate and high quality health care, including long-term care, and will provide for cost containment.

C. We believe it is morally and ethically wrong to deny more than 30 million of our people access to any kind of care, and to deny a very large percentage of our total population access to long-term care.

D. We believe it is fiscally irresponsible for our nation not to have a national health plan.

   1. We are confronted with uncontrollable spiraling health care costs.
   2. The experience of of other industrialized nations demonstrates that it is impossible to introduce effective cost containment in the health care field without having a national health plan.
   3. Therefore, a failure to enact and implement a national health plan is fiscally irresponsible from the standpoint of Federal, State, and local budgets, budgets of private sector organizations, and, above all, the budgets of consumers.

E. We believe we have the capacity and the will to finance a national health plan.

   1. Studies show that there will be savings in both the public and and private sectors in administrative costs.
   2. Nevertheless, there will have to be an infusion of additional public and private resources--one estimate based on a plan presented to your Committee would call for a 5% increase in our $600 billion health care bill.
   3. We believe a financing package --based on social insurance principles--can be developed and will be supported if the American people are assured that the revenues raised by the package will be used exclusively for health care.

III. Conclusion

A. We welcome the establishment of the Pepper Commission.

1. We welcome especially the fact that on or before March 1, 1990, this Commission will make "specific recommendations to the Congress respecting Federal programs, policies and financing needed to assure the availability of comprehensive health care services for all incidividuals in the United States."

2. We are confident that your recommendations on programs, policies and financing will add up to an action program designed to make it possible for us to join all the other industrialized nations of the world, except South Africa, in recognizing and implementing the right of access to health care.

B. Once your report is filed I believe that the action program will be supported by the broadest-based coalition that has supported any social program in the last 50 years.

C. The people are ready for and want action.

Chairman ROCKEFELLER. Thank you, Dr. Flemming. Are there questions for the panel? Dr. Davis.

Commissioner DAVIS. Mr. Chairman, I wanted to commend Mr. Mueller and Mr. Motley, both for emphasizing the disadvantage of State-mandated plans and this works disadvantageously to overall planning for overall health insurance. Many of these, of course, provide for wigs and other very inappropriate health care measures. May I ask you, in the interest of time, if you would be willing to write the Chairman an elaboration on your thoughts on State-mandated programs, if you will? Mr. Motley, will that be agreeable?

Mr. MOTLEY. Certainly.

Commissioner DAVIS. Thank you very much. This would be helpful.

Senator DURENBERGER. Mr. Chairman.

Chairman ROCKEFELLER. Doctor—I was going to say Dr. Durenberger. Go right ahead.

Senator DURENBERGER. I guess I'd like to ask a question of Mr. Motley and Mr. Mueller and maybe Arthur can respond to it also. I read all of your testimony, but I read Tom Burke's testimony and I'm going to encapsulate his characterization of who makes decisions in the system and see if you agree with it or disagree with it, particularly the two of you who are representing business here. I'm just going to read my notes now. This is not from Tom.

Financial protection against the consequences of ill health or accident, decisions are made in America largely in the workplace, at least at the expense of an employer, an employee, and the taxpayer, by persons both employers and employees who are unqualified to make these decisions, from programs administered by third-party brokers whose reasons for being traditionally have been to guarantee a reimbursement to providers of health care, which providers of health care are entrepreneurs of varying skills with a spotty relationship between the quality of their services and the price of those services. Now, Tom's looking at me like, where the hell did you get that? But at least in part that's in there.

Would either of you care to respond to that? I didn't try to do it in the pejorative, even though it may have come out that way. But as a characterization of the way we make decisions about health coverage, or whatever the title of this committee is, in America. Does that sound a little bit like kind of the way these things are done?

Mr. MUELLER. I'll start, I guess. No, it's not. I think it's an unfair characterization. I think some of those comments came over time. I think that the business community itself has gotten more into the health care area because of interest. Second, concern for their employees and value for their people that make up the business. Third, I think, as we do with anything in business regarding cost, we want to know where they come from, how they work. Health care is one of the few providers or suppliers to our companies that we don't have a good, constant relationship with because there's so many versus a few suppliers for a different part.

So, I think that the characterization, although it has some truth maybe years ago, I think today we're becoming more sophisticated. A quick answer to your question. We need to work further together, as we said in our testimony, as a group, not against one another. It's not a business problem, it's not a business solution, it's a societal issue. We have to—and we get the best people we can, both in the health care side and across the country, to participate in solutions. It's not a unilateral. In my organization I make the decisions that affect about 185,000 people. I don't make them in my office alone.

Mr. MOTLEY. I think from a small business standpoint, Senator, probably the characterization is much more accurate. And if the characterization is that you have a purchaser of a product over here who knows very little about the product that they're purchasing and even less about the steps in between, then you're right. And it's simply impossible for many small employers out there, many of whom—or roughly one-quarter of whom—don't even have their own accountants, to realize the dynamics that are taking place in the health care industry in this country today, much less the insurance industry. They're dumfounded by what is happening out there.

I was in Texas at the beginning of the year and sat and had dinner with five or six of our more active members and was literally shocked that the entire conversation was what was happening to them in their health insurance premium area. And they had no explanation for it, most of them had relatively normal businesses without an awful lot of unusual problems, and their insurance was going up rather rapidly. So, they were dumfounded. They really didn't know that much about the product that they were purchasing. They were completely at the will of somebody else. They don't have the resources to have somebody like Mr. Mueller to take a look at the problem and they're searching for answers.

So, I would have to come much closer to agreeing with that statement than he did.

Representative STOKES. Mr. Chairman.

Chairman ROCKEFELLER. Yes. Congressman Stokes.

Representative STOKES. Thank you, Mr. Chairman. I'd like to ask Dr. Flemming if he would care to elaborate somewhat on item 3 of your formal statement, on page 3, where you said: "We believe a financing package based on social insurance principles can be developed and will be supported if the American people are assured that the revenues raised by the package be used exclusively for health care."

You seem to be advocating a program in principle similar to that which we have now for Social Security, where you have simply a Social Security tax and revenues are derived and utilized for that specific purpose. Are you advocating that or you're talking of some form of a taxing financed program in addition to it? Could you just elaborate a little more for us on that principle?

Dr. FLEMMING. Thank you, Congressman. It seems to me that we should start with examining how we can expand to some degree the use of the payroll contributions, as we have used the payroll contribution approach in connection with our family income insurance program. For example, we all recognize that there's a ceiling now on payroll contributions. This year it's $48,000. Next year it will be $50,400. It goes up each year. Consideration can be given to raising that ceiling much higher. Consideration can in fact be given to eliminating the ceiling. That could yield a considerable amount of revenue. For example, if you just raised the ceiling on the Medicare portion, namely the 1.45 percent, that would yield between $8 and $9 billion a year.

Now, undoubtedly we will want to look for some additional sources of revenue also. And suggestions have been made that we may want to give further consideration to raising what people sometimes refer to as the sin taxes, the liquor and the tobacco taxes. Suggestions have been made that we may want to take another look at the estate tax. But the point is, that we can and should ask the entire national community, represented either by the working population or represented by the taxpaying population, to participate in the funding of the program.

It seems to me the basic lesson we've learned from Social Security is that we can go to the national community and ask the national community to pool its resources, whether it's represented by the working population or the taxpaying population, and get an affirmative response. We've had 50 years of experience with it and I feel it has been a good experience. And I see no reason at all why we shouldn't take policy we have followed in financing social insurance and apply it to dealing with the hazards and vicissitudes of health care.

Representative STOKES. Thank you very much, Dr. Flemming. Thank you, Mr. Chairman.

Chairman ROCKEFELLER. Jim Balog.

Commissioner BALOG. Thank you, Mr. Chairman. Mr. Burke, in your written testimony the basic idea that you're talking about is for the employers to pool themselves or individual employees and provide the primary care and then get preferred providers to provide the hospital care and so forth. What's the difference between what you propose and an HMO?

Mr. BURKE. There's not a great deal of difference between what I'm proposing and a group or staff model HMO with salaried physicians, and bringing it in-house. The problem you have with group and staff models is that they don't exist very many places in the United States and, again, the premiums are prohibitively high and the small employers can't afford them.

This system would offer a very honed down benefit package with a premium that would be affordable. Because the premium would be affordable they could take, at risk Medicare buy-ins they could also take the Medicaid eligibles and Medicaid could be uncoupled from the AFDC [Aid to Families With Dependent Children] so as to let Medicaid eligibility increase enabling it to include the near-poor. This would provide a much bigger base on which to spread the cost of the care. Now, the core of the issue is, we can continue to find more revenues to spend on health care or we can begin to change the system so that we spend it more efficiently.

We must start delivering care efficiently since we've proven in the last 20 years there's no limit to the amount of money we can throw into the health care industry without solving our access problems. From 6 to 12 percent of our GNP in less than a quarter of a century and I'm told it's going to 15 percent by the end of this century due to the demographics of the United States. So, it is a close relative of an HMO and it's something more and more corporations are beginning to explore implementing. We have a known track record from group and staff model HMO's and they have, in fact, held hospital utilization rates to one-half the rate in fee for service settings and there are incentives to provide good, quality care in HMO-type delivery systems.

Commissioner BALOG. Thank you very much.

Chairman ROCKEFELLER. Gentlemen, there are a variety of questions that I would like to submit in writing to you. We have two more panels and we need to finish by 1 p.m., and that's unfortunate because I think there could be some excellent discussion. So, if you would be willing to answer questions in writing, that would be very, very grateful. Thank you so much for coming and giving us your perspectives.

Mr. MOTLEY. Thank you, Mr. Chairman.

Chairman ROCKEFELLER. Our next panel has to do with providers. Dr. Marvin Kolb is chair, Council on Government Affairs, the American Academy of Pediatrics; Dr. Vivian Pinn-Wiggins, president, National Medical Association; Kathleen Higgins, American College of Nurse-Midwives; and Paul Rettig, executive vice president, American Hospital Association. And Dr. Kolb——

Dr. KOLB. Yes, sir.

Chairman ROCKEFELLER [continuing]. We'd like to start with you, sir.

STATEMENT OF DR. MARVIN O. KOLB, CHAIR, COUNCIL ON GOVERNMENT AFFAIRS, AMERICAN ACADEMY OF PEDIATRICS

Dr. KOLB. Thank you, sir. Mr. Chairman and members of this Commission, I'm Marv Kolb representing the American Academy of Pediatrics. I'm pleased to be invited today to address the issue——

Chairman ROCKEFELLER. Would you put that microphone a little bit closer?

Dr. KOLB. Sure. Yes, sir.

Chairman ROCKEFELLER. Thank you.

Dr. KOLB. How's that?

Chairman ROCKEFELLER. That's better.

Dr. KOLB. Thank you, sir. I'm pleased to be invited today to address the issue of providing affordable, quality health care for the American people. Pediatricians support this goal and will work to that end.

However, in the initial steps of providing universal access, the urgent needs of children and pregnant women should be addressed first. I know that you, Chairman Rockefeller, and other members of this Commission are well aware of the shameful rate of infant mortality in our country, the increasing outbreaks of preventable diseases among unimmunized children, and the litany of indicators that show that too many children and pregnant women do not get the health care services they need. While lack of adequate health insurance is not the only barrier to participation in our health care system, it is a fundamental obstacle that must be removed.

The majority of health insurance in America is provided through employers and the availability of employer-based insurance, especially for dependents, is declining. Because economically pressed employers have either dropped dependent health coverage, they are reducing benefit packages, or they're requiring employees to pay a higher premium share for dependent coverage. Hence, the majority of uninsured in our country are children and pregnant women.

Even for those individuals who have insurance, coverage can be limited. Insurance programs pay for surgery or hospitalization, but often do not reimburse for preventive services, acute services, outpatient care, and counseling services for substance abuse, nutrition, and healthy lifestyles. Prevention programs work. These are the services children and adolescents need most and these are the services that can often eliminate more costly procedures and minimize hospitalization.

The Academy of Pediatrics has developed a proposal which insures universal access to health care for all children and pregnant women. With minimal disruption of our existing system, our proposal would expand the delivery of prenatal, preventive, and primary health care services by coordinating the efforts of the public and private sectors without requiring new Federal dollars.

Our proposal is designed to assure universal access to health insurance with a standard benefit package for all children through age 21 and pregnant women. A standard benefit package will be designed to insure quality of care with benefits arranged into three categories: preventive benefits, primary major medical benefits, and care-coordinated benefits. Benefits will be equally available through employer-based insurance or through the State-administered insurance fund, thus insuring a mainstream, one-tier insurance system.

Employers who offer insurance to their employees will have the option of providing for their dependents a standard benefit package as defined by legislation or paying approximately a 3½-percent payroll tax. In addition to the payroll tax, the State-administered fund will be financed through Federal and State Medicaid funds, through premiums, and through copayments.

In our plan, for families below 130 percent of the Federal poverty level, no deductible and no premiums will be required. For those whose incomes are between 130 and 200 percent of poverty a sliding scale would be applied and there is an annual out-of-pocket cap of $1,000 per individual or $3,000 per family. It is possible that an alternative funding strategy could be adapted to this proposal.

Our proposal suggests a dual role for the Federal Government and for the State governments. The Federal Government will insure uniformity of benefits, while the State governments will enjoy flexibility in management. The objective is to streamline the bureaucracy and enhance coordination at the Federal, State, and local levels.

We're concerned about the health care of all Americans, of all segments of our population. This country needs a program that provides universal access. However, it makes economic sense and just plain common sense to phase in systematic reform by starting with the neediest and most vulnerable segment of our population, children and pregnant women. To make a difference in the future we have to take bold steps today.

Our proposal can serve as a blueprint to build opportunities for infants, children, and young adults and pregnant women to enjoy the improved health care they deserve and to lay the foundation for a better health care for all America. I thank you, sir.

[The prepared statement of Dr. Kolb follows:]

American Academy of Pediatrics

TESTIMONY

BEFORE THE

"THE PEPPER COMMISSION"

UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

"CHILDREN FIRST IN UNIVERSAL ACCESS"

PRESENTED BY

MARVIN O. KOLB, M.D., F.A.A.P.

OCTOBER 24, 1989

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SUMMARY

Access to quality, affordable health care for all children and pregnant women must be addressed first in the national movement toward a universal health care system.

The case for children:

- Up to 16 million children through age 21 (1 out of 5) are uninsured. Not only are these uninsured children often unable to get medical attention when they are sick, they also do not get preventive care which can save money in the long term.
- There are approximately 4.5 million uninsured adolescents (10-18 years old). Adolescents are a high risk pregnancy group and are the population most at risk for substance abuse. Adolescents will make up the labor force of the 1990's.
- Over 14 million women of childbearing age do not have insurance for prenatal and/or maternity care. The U.S. ranks lower than 18th internationally in infant mortality.

The Academy has developed a proposal through which all children up to age 21 and pregnant women would have access to private health insurance either through employers or through a state-administered insurance fund. Both systems would be required to provide a standard benefit package, thus assuring quality care and a one-tier system for all.

Through federal legislation, our proposal would:

- Build on and improve the existing employer-based system which provides health insurance to employees and their dependents.
- Develop, for children and pregnant women without employer-based insurance, a parallel system of insurance through a state administered insurance fund (SAIF).
- Allow maximum flexibility at the state level for program administration within guidelines established at the federal level.
- Utilize existing health care delivery models with procedures that are simple and easy to use for both the provider and the patient.

The state fund would be financed through multiple sources, including federal and state funds currently designated for the children and pregnant women's portion of Medicaid, premiums and co-payments for those participants with sufficient incomes and an approximate 3.5% employer payroll tax levied only on those employers who do not extend insurance coverage to dependents.

With as little disruption of the existing system as possible, our proposal would expand delivery of prenatal, preventive and primary health care services to all children and pregnant women by coordinating efforts of the public and private sectors, without requiring new federal dollars. While the Academy supports universal access to care for all Americans, children and pregnant women's urgent needs should be met first, and this system should serve as a foundation.

Mr. Chairman, members of the Commission, I am Marvin Kolb, M.D., chairman of the American Academy of Pediatrics' Council on Government Affairs. I am pleased to be invited here today to address the issue of providing affordable, quality health care to the American people. While the Academy supports this laudable goal and will work to that end, I come to you today with the strong bias of the 37,000 pediatricians I represent. We believe that the needs of children and pregnant women are urgent, and if all uninsured persons cannot be covered in the immediate future, the needs of our most vulnerable population -- children and pregnant women -- should be addressed first.

This testimony will reflect the diligent attention and actions of the Academy over the past year to develop a proposal to ensure access to quality health care for all children and pregnant women. In shaping our proposal, we have reviewed the many options before you addressing the issue of access to care. Our proposal combines the best aspects of these plans to create a comprehensive, cost effective approach to solving the problem of access to care for children and pregnant women.

The American Academy of Pediatrics' proposal rebuilds the foundation of the American health care system by starting with children and pregnant women. With as little disruption of the existing system as possible, our proposal would expand the delivery of prenatal, preventive, acute and chronic care and other primary health care services to all pregnant women and children by coordinating efforts of the public and private sectors, without requiring new federal dollars.

We believe this proposal is reasonable, affordable and obtainable and meets the needs of all children. We clearly recognize and appreciate the fiscal constraints that will be placed on you as you craft a universal proposal and we will make a strong case for meeting children's needs first.

The Case for Children

Through the years, many strides have been made to improve children's health. We now have the ability to prevent measles, polio and some types of meningitis. We also possess the knowledge and technology necessary to screen for uncommon genetic disorders, to diagnose developmental delays in infancy and to effectively treat premature infants to prevent disability and death. We have increased public awareness of the importance of product safety and healthy lifestyles and we have made progress in the critical area of prevention of unintentional injuries and deaths.

Yet, for all the children we have been able to help, there are millions more we have not reached. They are the children, who, for varied reasons, do not have access to adequate health care.

For the most part, children and pregnant women without financial access to care fall into three categories: the uninsured, the underinsured and the uninsurable.

Today, data suggest that as many as 16 million children through the age of 21 may be uninsured. That is one out of every five children and adolescents. Surprisingly, a large number of these children do not come from stereotypical "poor families." More than half of all uninsured children live in families with incomes above the poverty line. Three-fourths are white and more than half live in two-parent families. Approximately two million uninsured children live in families where one or both parents have employer-purchased health insurance.

Not only are uninsured children unable to get medical attention when they are sick, but they also do not get preventive care. The consequences of lack of preventive care are many. Studies show that uninsured children are approximately 20 percent more likely to be reported in poor health than are children with insurance. Uninsured children are less likely to be immunized than children with insurance. One in three poor children is not immunized at age 2 against rubella, measles and mumps. Not surprisingly, the number of reported cases of measles is rising, as are the incidences of pertussis and mumps.

Developmental delays and vision and hearing problems are also less likely to be detected in uninsured children, since often when preventive care is not received these problems are not recognized until school entry. This leaves many children with long-term problems which could have been treated and without access to a health care system which could help them maximize their potential.

In addition to the alarming number of uninsured children, over 14 million women of childbearing age do not have insurance for prenatal and/or maternity care. One out of every four pregnant women receives no prenatal care during her first trimester. As a result, problems that might have been detected through early prenatal care may unnecessarily complicate pregnancies. Lack of counseling about proper nutrition and use of alcohol, tobacco, drugs, etc., can result in low-birthweight babies and a high rate of infant mortality. In fact, the U.S. infant mortality rate places the U.S. 18th among the western industrialized nations.

Another extremely significant group that is disenfranchised from the current health care delivery system and needs immediate attention is our adolescents. In the 10-18 year-old category, approximately 4.5 million are uninsured. The majority of children in this category are poor or near poor, black or hispanic, have parents who have not completed high school, or live in single parent households.

Studies tell us that expense is the major reason for the lack of insurance in the adolescent population. Significant numbers of adolescents suffer from chronic conditions that limit normal activity. The leading causes of disability among adolescents are emotional disorders and respiratory diseases and these are more prevalent in young male adolescents ages 10-14. Adolescents are also a high-risk pregnancy group and a group at risk for substance abuse. It is this population that will make up the labor force, which is anticipated to have a significant shortfall, in the mid-1990's.

In addition to the problems of the uninsured, millions more children and women of childbearing age are underinsured -- meaning that they are without adequate insurance coverage for necessary medical services. Still others are "uninsurable" meaning that in our current systems they are barred from purchasing health insurance because of preexisting chronic or re-occurring conditions.

We recognize that the access crisis is caused by many different barriers to care. For example, existing health care delivery systems do not have adequate services to meet the needs of special populations, such as disabled children. There are too few preventive programs for problems such as teen suicide and substance abuse. Inner cities and many rural areas lack conveniently located physicians or quality child health care services. Low Medicaid reimbursement and excessive paperwork limit the number of Medicaid patients practitioners will accept and, in fact, is sometimes a disincentive to accepting any Medicaid patients at all.

However, before we can adequately address these varied impediments to care, the fundamental barrier that must be removed is absence of -- or inadequate -- medical insurance. And before we can solve the insurance problem, we need to carefully examine it in light of the special needs of children.

Health Insurance and Children

Today, the majority of health insurance in America is provided through employers. However, the availability and quality of employer-based insurance, especially for employee dependents, is declining as economically pressed employers have either dropped dependent health insurance, reduced the benefit packages, and/or required employees to pay a higher premium share for dependent coverage. In 1984, for example, 38 percent of all employers offered fully paid insurance coverage for their employees' dependents. By 1988, that proportion had declined to 32 percent.

Additionally, the health insurance system in this country does not ensure access to "health" care even for those who have insurance. Instead, those who are insured have access to "sick" care, because our current system encourages utilization of expensive acute care and discourages use of preventive services. If there is one thing we have learned from our experiences with preventive programs such as immunizations and prenatal care, it is that preventive medicine works. Moreover, it is much less costly than emergency and hospital care and care for chronic disease and disability. Insurance often covers inpatient hospital care and surgery and infrequently covers preventive and acute illness outpatient care. It is those latter services that children need most and which can often prevent more costly procedures and hospital care. Our proposal reflects the fact that dollars spent on preventive care and for early treatment of acute illnesses are the most cost effective.

The AAP Proposal

The Academy's proposal is designed to eliminate financial barriers to care for all children and pregnant women in the most efficient, reasonable and cost effective way possible. In meeting all these challenges our proposal will provide:

- Universal access to health insurance for all children through age 21 and pregnant women.

- Quality health care through a standard benefit package.

- Preventive services at no cost to beneficiaries.

- Freedom of choice for patients and providers.

- Fair payment for providers.

Our goal of ensuring access to quality care will be met by creating, through federal legislation, a mechanism to:

1. Build on and improve the existing employer-based system providing health insurance to employees and their dependents.

2. Develop, for children and pregnant women without employer-based insurance, a parallel system providing private health insurance through a state administered insurance fund (SAIF).

3. Rechannel into the state fund federal and state monies for children and pregnant women currently served by the Medicaid program.

4. Allow maximum flexibility at the state level for program administration, within guidelines established at the federal level.

5. Utilize existing health care delivery models with procedures that are simple and easy to use for both the provider and patient.

All children and pregnant women would have access to private health insurance through employer financed insurance or a state administered insurance fund. Our proposal suggests a dual role for federal and state governments. The federal government will establish high standards, while the states will enjoy flexibility in administration and management. The objective is to streamline the bureaucracy and enhance coordination at the federal, state and local levels.

A standard benefit package will be provided to ensure quality of care. Benefits are arranged into three categories:

1) Preventive benefits:
Including preventive care visits at clearly defined intervals, prenatal care, care of newborns and child abuse assessment. Regardless of income level or insurance system, no co-payments or deductibles will be applied.

2) Primary/major medical benefits:
Including care for acute and chronic illness, hospital care, subspecialty consultations, emergency room care and drugs and laboratory tests. There will be a maximum deductible of $200 and a maximum co-payment of 20% of

the total charges for services in this category based upon income.

3) Care coordinated benefits:
Including mental health, substance abuse, and treatment of developmental and learning disabilities. There will be case management of the benefits in this category. As with the major medical benefits, cost sharing applies. There will also be caps for benefits in this category.

There is a limit on out-of-pocket expenses for enrollees in both systems. The limit will be 10% of income up to a maximum of $1000/year for an individual and $3000/year for a family. The proposal will provide appropriate directly financed services, including services provided through health care clinics, regionalized community-based programs for children with special health needs, and regionalized perinatal services. Public health programs for children, such as lead poisoning, injury prevention, child abuse and genetic screening will be strongly emphasized.

An important point is that these benefits will be equally available both through employer-based insurance and the state administered fund.

Employers who offer insurance to their employees will have the option to provide the standard benefit package for children and pregnant women, as defined by the legislation. Employers who choose not to offer insurance to children and pregnant women, or who offer less than the defined package, will pay a payroll tax of approximately 3.5%. Employees enrolled in the employer-based system will be responsible, as they usually are for premium payments, deductibles and co-payments.

All children and pregnant women who do not receive insurance through an employer will have access to private health insurance through a state administered insurance fund. Those receiving insurance through the state administered system will include, but not be limited to:

- Pregnant employees, pregnant dependents and children of employed families whose employer does not offer insurance.

- Pregnant employees, pregnant dependents and children of employed families whose employer offers a package that does not meet the benefits standard.

- Pregnant employees, pregnant dependents and children of employed families who opt out of the employer-based system and choose to enroll in the state fund.

- Pregnant women and children who currently receive Medicaid.

- Unemployed pregnant women and children of the unemployed.

- Self-employed pregnant women without insurance, pregnant dependents and children of the self employed without insurance.

States will have broad latitude in administering the system, while adhering to specific requirements in areas such as benefits and choice of insurers. The function of the administering agency will be defined, but the designation of the agency will be determined by each state. This flexibility will stimulate a pluralistic, competitive environment to enhance quality and serve as an effective means of cost containment.

The state-administered insurance fund will be funded by a combination of revenue including:

- A 3.5% payroll tax on employers not offering insurance to dependents or not offering the required benefits.

- Individual premium payments by families enrolled in the state fund whose incomes are above 200 percent of poverty. For those families whose incomes fall below 130 percent of poverty, no payment will be required. Co-payments and deductibles for families with incomes between 130 and 200 percent of poverty would be partially subsidized by the state fund.

- Federal and state dollars allocated for the children's and pregnant women's portion of Medicaid will be transfered to the state fund. A maintenance of effort provision will be included to ensure that states do not decrease existing funding levels.

With the implementation of this plan, all children and pregnant women will have access to health insurance, with a complete package of quality health insurance benefits. It is assumed that employers will choose the least expensive option. It is estimated that under the proposed plan, of employers who currently offer insurance, 70 percent will maintain and improve their benefit plan, while 30 percent will discontinue dependent coverage. Of those firms that do not currently offer insurance, 21 percent will purchase coverage, while 79 percent will opt to pay the payroll tax.

Children First

We must emphasize that we are sympathetic with the health needs of all segments of our population and that this country should strive toward a program that provides universal access for all Americans. However, if a phased-in approach is needed, our plan should serve as the foundation.

We urge you to take the bold step and advocate for a system that provides comprehensive health care for the neediest and most vulnerable segment of our population -- children and pregnant women. It makes good economic sense and it is just plain common sense. It is doable; it is right; and it will make a difference in the future of this country. As Theodore Roosevelt once said, "each child represents either a potential addition to the productive capacity and enlightened citizenship of the nation or, if allowed to suffer from neglect, a potential addition to the destructive focus of a community."

Chairman ROCKEFELLER. Thank you very much. Just before we go on to the next witness, because I'm afraid that either of our two Jims may have to leave at a certain point, I want to point out that it's interesting to me that coming from North Carolina and coming from New York appears to be a more regular habit on this Commission than some of those who simply have to come from one of two or three buildings in this complex. So, I want to thank both Jim Davis and Jim Balog for their constant attendance at these hearings, most of which are in private, but some of which are in public.

And, you know, the public I think sometimes when they look at the number of Commissioners they make a judgment as to how committed the Pepper Commission is. I hope that that judgment will not be made. It's a very committed Commission that seems to be more committed in private sessions than it is in public sessions and I regret that.

So, with that interesting comment, Dr. Pinn-Wiggins, we'd be delighted to hear from you.

STATEMENT OF DR. VIVIAN W. PINN-WIGGINS, PRESIDENT, NATIONAL MEDICAL ASSOCIATION

Dr. PINN-WIGGINS. Thank you, Mr. Chairman, members of the Commission. I'm here to represent the National Medical Association [NMA], which is an organization composed primarily of minority physicians, and of those, predominantly black physicians. We are dedicated to improving the health care status for all Americans and we are especially concerned about the plight of the poor, the underserved, and minority populations in this country.

Chairman ROCKEFELLER. Could you pull that closer, please?

Dr. PINN-WIGGINS. Sure. We have aggressively sought to insure equal access to and availability of quality health care services for all peoples. During the past 94 years the NMA has had among its leaders and its members those who are among the primary providers to those persons most affected by the policies addressed in this Commission. Therefore, we are most appreciative of the opportunity to share our observations and our suggestions with you.

We recognize that there have been good reasons why the health care delivery system in this country has been under scrutiny during the last decade, especially because of the escalating health costs, and we certainly recognize the need for health care reimbursement reform. However, we have concerns that much of the health care financing reform has inadvertently placed health care for the poor and minorities in jeopardy.

I'm sure you're familiar with the Report of the Secretary's Task Force on Black and Minority Health which was published in 1985, which documented what we had already thought to be true; that blacks and other minorities suffer disproportionately from diseases such as diabetes, hypertension, kidney disease, heart disease, and various forms of cancer.

This report documented that approximately 59,000 black Americans die each year who should not have died if their health status was the same as for other nonminority Americans. It is also worthy of note that these so-called excess deaths are mostly related to illnesses which are potentially preventable, curable, or treatable.

Recent newspaper reports are certainly not news when they talk about our patients going to the hospital, the emergency rooms, or clinics for care. We have known for many years that the disadvantaged and the minority too often use emergency rooms as others would use a private physicians office for their first contact or primary contact for health care. Many of our patients delay getting medical care until the situation has become critical and then a clinic or emergency room visit demonstrates a patient too often who may be more chronically ill or have a more advanced state of disease. Of importance is when such patients are finally seen, these underinsured, uninsured, or medically underserved for a variety of reasons, they're more apt to have not one, but multiple illnesses, and to require comprehensive costly treatment.

We have serious concerns regarding the Prospective Payment System which pays a flat rate for medical treatment. It does not adequately take into consideration the complications or severity of illness. What is truly the fiscal responsibility and financial burden for those hospitals and physicians which have accepted the responsibility of taking care of them? How are they affected or rather how should they be affected for their voluntary humanistic services or their obligatory health care provisions?

We, as minority physicians, are all mindful of the high costs and yet increasing costs of medical care in this country and we all have a vested interest in bringing them under control. However, we do feel that too many hospitals which treat low-income patients must write off too much money in uncompensated care each year. NMA has given thought to these problems and we have a few suggestions.

One, that the DRG system should be reevaluated for its effect on quality of care for poor and minority patients and that a cost adjustment be made for severity of illness and intensity of services when indicated.

That there should be continued support for Medicaid with adequate funding, standard eligibility requirements in each State, standard benefits in each State, along with reasonable physician reimbursement, physician participation in revisions, and a refinement of the paperwork required to create a more efficient documentation. The Federal Medicaid regulations should be reevaluated such that each State be required to make all of the indigent eligible for prescription drugs for chronic diseases, such as hypertension, without the additional requirements of disability, age, or dependent children, and that special provisions should be considered for hospitals which operate at a loss because of their large proportion of Medicaid and Medicare patients.

I'd like to just say another bit about preventive services, which have been addressed by other testimonies this morning. We reaffirm the position that affordable basic health care is a legal right for all citizens and we do support a national health program that provides coverage to all Americans. However, we do believe that early detection and prevention should be a part of any health care legislation which does come about.

Health screening programs are not routinely funded or provided. And we do believe, in keeping with the Federal Government's desire for health promotion and disease prevention, much can be done to cut down on the cost of long-term care by putting money into screening programs and allowing for such documented procedures such as mammography, Pap tests, testing for tuberculosis, rectal examinations, and simple checking of blood pressure to prevent advanced chronic diseases.

I have included, in what I've submitted to you, other ideas which we have and I thank you very much for the opportunity to be with you today.

[The prepared statement of Dr. Pinn-Wiggins follows:]

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TESTIMONY TO

THE PEPPER COMMISSION

United States Bipartisan Commission on Comprehensive Health Care

Vivian W. Pinn-Wiggins, M.D.
President
The National Medical Association
24 October 1989

TESTIMONY TO
THE PEPPER COMMISSION
United States Bipartisan Commission on Comprehensive Health Care

Vivian W. Pinn-Wiggins, M.D.
President
The National Medical Association

INTRODUCTION

The National Medical Association (NMA) was founded in 1895 and represents over 16,000 physicians residing in all 50 of the United States, as well as Puerto Rico and the Virgin Islands, most of whom are minority, and of those, most are Black (African American). The National Medical Association recognizes, among its founding objectives, the nurturing of the growth and diffusion of medical knowledge and the prompt universal delivery of this knowledge to all people by means of an adequate health care delivery system. We are dedicated to improving the health care status for all Americans, and we are especially concerned about the plight of the poor and minority populations in this country.

The NMA actively addresses issues which impact upon the ability of its members to deliver quality health care and our patients to receive quality health care. We have aggressively sought to ensure equal access to and availability of quality health care services. During the past 94 years the NMA has had among its leaders and its members those who are the primary providers to those persons most affected by the policies addressed in this Commission.

Therefore, we are most appreciative of the opportunity to share our observations and suggestions with you. As you requested we have divided our testimony into two categories, assuring access to health care and assuring access to long term care.

I. ASSURING ACCESS TO HEALTH CARE

The health care delivery system in this country has been under careful scrutiny during the last decade, especially because of escalating health care costs. Legislation has been passed which has purposely changed the way medicine is practiced in this country, and the ways in which health care reimbursement is determined. Unfortunately, much of this health care financing reform inadvertently has placed health care for the poor and minorities in jeopardy.

In 1985, The Report of the Secretary's Task Force on Black and Minority Health published data documenting that Blacks suffer disproportionately from diseases such as diabetes, hypertension, kidney disease, heart disease and various forms of cancer. This report also documented that approximately 59,000 Black Americans die each year who should not die IF their health status was the same as for other non-minority Americans. It is also worthy of note that these so-called "excess deaths" are mostly related to illnesses which are potentially preventable, curable or treatable.

Data also outlined the fact that this same patient population often first obtains health care in one of two ways: the emergency room or clinics, either hospital or community based. Recent newspaper reports are certainly not "news" because we have long known that the disadvantaged and the minority too often use the hospital emergency room as others would use a private physician.

While middle-income patients obtain most of their health care from physicians in private practice, and have either the funds or the health insurance coverage to benefit from preventive medical practices, many of our patients delay getting medical care until the situation becomes critical; then, a clinic or emergency room visit often demonstrates a patient who may be more chronically ill, or have a more advanced state of disease. The reasons for their delay is often due to their actual, or perceived, inability to "purchase" quality medical services. Of importance is that when such patients are finally seen, these underinsured, uninsured, or medically underserved for a variety of reasons, they are more apt to have not one, but multiple illnesses, and to require comprehensive costly treatment.

We have serious concerns regarding the Prospective Payment System, which pays a flat rate for medical treatment; it does not adequately take into consideration complications or severity of illness. What then happens when a patient may need to be admitted to a hospital with heart disease, high blood pressure and acute renal failure? What is the fiscal responsibility and financial burden for those hospitals and physicians which have accepted the responsibility of taking care of them? How are they affected, or rather how should they be affected for their voluntary humanistic services or their obligatory health care provision?

In 1985, the House Ways and Means Committee contacted then Secretary of Health and Human Services, Margaret Heckler, the same Secretary who commissioned the Task Force Report on Minority Health, to express its concerns over the special needs of hospitals that serve significantly disproportionate numbers of low income and Medicare beneficiaries. The Committee realized the potentially harmful impact the Prospective Payment System would probably have on these hospitals. It asked the Secretary to review evidence that was being compiled concerning the linkage between low income patients and higher Medicare costs per case, so that corrective action could be taken. The NMA maintains that this same type of reasoning should be given to all medical legislation and regulation. Not only because it is morally right, and it is morally right, but because it also makes good sense.

We as minority physicians, are all mindful of the high costs, and yet increasing costs, of medical care in this country, and we all have a vested interest in bringing them under control.

Hospitals which treat low income patients often must write off millions of dollars on uncompensated care each year. Howard University Hospital, where I am Chairman of the Department of Pathology, writes off more than $30 million in uncompensated care per year, second in the District of Columbia only to D.C. General, the city-run hospital.

NMA has given careful thought to these problems and would like to suggest the following:

1. The DRG system should be reevaluated for its effect on quality of care for the poor and minority patients, and that cost adjustment be made for severity of illness and intensity of services when indicated. Also, many of our patients lack adequate housing support systems for post-hospital care. There should and must be some provision of step-down supportive services for low income patients.

2. There should be continued support for Medicaid with adeqnate funding, reasonable physician reimbursement, physician participation in revisions of the program, and a refinement of the "paper work" required to create a more efficient documentation.

3. The Federal Medicaid regulations should be reevaluated such that each state be required to make all of the indigent eligible for prescription drugs for chronic diseases such as hypertension without the additional requirement for disability, age or dependent children.

4. That special provisions be made for those hospitals which operate at a loss because of the large proportion of Medicaid and Medicare patients they serve.

5. That we devise better strategies to increase the numbers of minorities in health professional fields because it has been documented that they are more likely to serve in medically underserved areas.

Under the present health care system in the United States many persons are uninsured, or underinsured including many below the poverty level. There is a significant percentage of Black Americans who still can not obtain Medicaid. Many small business persons cannot afford health insurance protection due to the high cost of premiums. Many persons are uninsurable because of chronic disease conditions.

It is estimated that 37 million Americans lack health insurance; of those 75% are members of working families; 15 million women of child bearing age are uninsured and there are 11 million uninsured children.

The National Medical Association reaffirms its position that affordable basic health care is a legal right for all its citizens and that the NMA supports a National Health Program that provides coverage to all Americans regardless of income, race, sex or ethnic origin and provides access to primary quality care with high professional standards. The NMA proposes that a system of health care delivery and financing be considered, involving a mix of employer/employee contributions, general tax revenues, and subsidization of the cost of health care delivery for the poor.

The NMA has supported a national health plan since 1978, with the benefits of guaranteed access. We also support comprehensive health care with emphasis on prevention; freedom of choice between provider and patient; government assurance of quality medical care with representative minority participation; and compliance with Title VI of the Civil Rights Act.

II. ASSURING ACCESS TO LONG TERM CARE

The availability of health care resources for the chronically ill, most of whom are over 65 years of age, remains a major problem of our society. This is particularly true since many Medicare beneficiaries have the mistaken impression that the expenses of chronic illness are covered by the Medicare program. Many others mistakenly feel that private insurance plans will adequately cover long-term care expenses and fail to realize that this is not necessarily true.

NMA's Board of Trustees recognizes this continuing problem and in 1988 established a Long Term Care Task Force to study the problem of long term care and to make recommendations about the solution from an NMA perspective. We found that the definition for long term care includes not only the elderly but also disabled persons (individuals who are mentally retarded and those suffering from developmental, traumatic or neurological disabilities). It also includes babies, born of drug-addicted mothers, who experience developmental or neurological disabilities.

FINANCING

As you are aware, in 1965 the Medicare and Medicaid programs began to finance acute care medical services for the elderly. The financing of long term care services has often fallen on the Medicaid program, especially for nursing home services but also for home and community based services. Thus, Medicaid, a program initially designed for low income women and their children, has become the major payer for middle income older people who have exhausted their assets to meet the devastating needs of long term care.

As this trend escalates, the NMA has expressed serious concern that the Medicaid program will not be able to expend funds for coverage and benefits for the low income mothers with young children due to strict budget constraints and the cost of financing long term care services. During an era where teenage and single parentage are on the rise and babies born of alcohol and drug addicted parents are increasingly being abandoned in hospitals, the concern becomes even greater.

EARLY DETECTION AND PREVENTION

The belief that disability and aging are synonymous causes many elderly persons to accept ill health as a normal consequence of longevity. This problem is greatly exacerbated in the minority community because many minorities have come to believe that illness is also synonymous with being born poor. The NMA firmly believes that preventing long term disability by early detection through health screening programs is an efficient use of public dollars. Programs should be funded to:

1. Educate the public as to availability of services such as Meals on Wheels, Adult Day Care Centers, Free Feeding Programs, Transportation, etc. which can improve their general health status and supportive needs. There needs to better coordination of information regarding available services through physicians' offices, clinics, community agencies or civic offices in order to increase the use of primary medical care, increase the emphasis on physical fitness, and foster nutrition programs, provide physical and mental activity, and a total environmental approach to health care.

2. Although health screening programs are not routinely funded nor provided by health programs, the NMA does believe that, in keeping with our federal government's desire for "health promotion and disease prevention", much can be done to improve the status of health of all Americans and to decrease the cost of long term health care through comparatively minor costs of health screening programs. There are some specific tests which have been documented to be particularly important because the diseases for which they screen are common, and can be treated, prevented or cured. Mammography for detecting breast cancer for which the mortality rates have been increasing, PAP smears to detect cervical cancers, testing for tuberculosis which has begun to appear more commonly again in inner city areas, rectal examinations, both digital and for occult blood, for early detection of colorectal cancer, and a simple checking of the blood pressure to prevent severe cardiovascular diseases, strokes, myocardial infarctions and end stage renal disease.

Any new health legislation, especially if it is concerned about cost containment in health care and the cost for long term care, should consider funding these and similar screening methods for early detection and prevention of chronic diseases which will require expensive long term care.

The care of the hospitalized disabled and the elderly is a concern. It is not uncommon that following prolonged hospitalization, the elderly and the disabled may become more debilitated and dependent. Special geriatric or gerontology units are needed in acute hospitals with trained specialists who are concerned about rehabilitation of the long term care patient.

NMA's philosophy is that as part of the prevention of illness for this population, the use of multi-disciplinary team involving family members should be expanded. We would suggest considering a means to recognize family who could best devote their time to the care for the disabled long term care patient in the home setting, but who then are forced to sacrifice their income-producing jobs if they assume this responsibility.

The NMA believes that the concept of respite care should be expanded and funded as part of a program to expand the role of the family in the delivery of long term care. The traditional organizations in the Black community such as churches, sororities/fraternities, and private clubs, are viewed by the NMA as vital resources. These organizations have been and should be involved in the needs of long term care persons in home and community-based settings.

TRAINING

The NMA is concerned about the lack of training of health professionals to adequately meet the needs of minority and poor patients, the medically indigent, especially those with long term care needs. From the physician to the home health aide or visiting nurse, from the administrator to the social worker, new or expanded programs for training are needed. The NMA recommends that concerted effort be made for all health professional schools to develop curricula that stress the needs of long term care patients to include their cultural and social requirements as well.

The need for public funding of such educational programs is critical. Special emphasis should be made on the selection characteristics of professionals going into the long term care field in order to select those better equipped to deal with the long term frustrations and seemingly, at times, unrewarding demands of that field. Medical schools and hospitals should assure that physicians are trained in current approaches to long term care and the need for coordinated and comprehensive and health care delivery for such patients.

LONG TERM CARE FACILITIES

The role and function of long term care facilities, such as nursing homes, home health agencies, community residence facilities, day care centers, need to be reexamined and reassessed. Greater emphasis should be on rehabilitation and restoration of function and not on warehousing and maintenance of "status quo". The nursing care at such facilities is a serious problem as it is in urban and rural hospital settings.

The NMA would also suggest that Medicare and Medicaid programs should require more frequent physician visits to nursing home patients, rather than the existing 30-60 day requirement. In addition, yearly assessment and yearly evaluation by regulatory agencies charged with the evaluation certification of long term care facilities must be stressed. This standardization and tighter control are recommended for various home health agencies and any provider of long term care services.

In closing, let me emphasize that the National Medical Association stands ready to assist the Congress in structuring and implementing any new programs which may result from this gathering. We do have a concern regarding the lack of basic race specific data, including the extent of long term care problems in the Black communities. It is widely felt that an improved data base to assess the needs and to better deal with the issues confronting the Black, and other minority, or economically disadvantaged patient would greatly help to improve existing modes of treatment and outcome.

Thank you very much for the opportunity to be with you today.

Chairman ROCKEFELLER. Thank you very much. Kathleen Higgins.

STATEMENT OF KATHLEEN M. HIGGINS, CNM, AMERICAN COLLEGE OF NURSE-MIDWIVES

Ms. HIGGINS. Good morning, Mr. Chairman. My name is Kathy Higgins and I'm here today representing the American College of Nurse-Midwives and president Joyce Beebe Thompson. I'm currently a nurse and a nurse-midwife and am attending the University of Pennsylvania as a full-time doctoral student, where I'm pursuing a dual degree in a Ph.D. in nursing administration and a Wharton M.B.A.

As you may know, nurse-midwives have been providing preventative health care services in this country since the latter part of the 1920's when they demonstrated their performance in the hills of Kentucky. We have demonstrated our commitment to underserved and patients who have difficulty receiving services for many decades now. Nurse-midwives primarily provide care for women and their families. Not only, however, through the time of pregnancy, labor and delivery, and the immediate postpartum and neonatal periods, but also for family planning and GYN services throughout their lives.

A couple of experiences that I had last week I thought might help to demonstrate the kinds of work that we're currently providing. To offset some of the expenses of the University of Pennsylvania educational program, I'm providing a teaching assistantship with the graduate program in nursing. And as part of my responsibilities last week graduate students, who are learning to be nurse-midwives, accompanied me to a variety of clinical sites.

The first one was in Allentown where we were working in an out-of-hospital birthing center. There was a woman who was a few days overdue with her first baby, was very anxious to go into labor. The telephone rang about 4:30 in the morning, maybe it was that rainy moonlit night, I don't know, but anyway, we all went into the birthing center with the family and she proceeded to deliver a healthy baby boy that afternoon. Throughout the day she was provided care by the nurse-midwives and the support staff. Her family was very much involved.

At the same time, the nurse-midwives were providing prenatal care to a number of mothers who were part of their package there. And also once these moms have delivered, the nurse-midwives and nurses go to their homes to provide postpartum care and then they return there for their followup.

For that kind of intensive, quality, very humanistic care, the reimbursement is very, very limited. And so, the nurse-midwives, in order to make ends meet, are really having to consider limiting the number of Medicaid reimbursed patients that they can accept. You will notice from the materials that we provided for you, it's not surprising that that's the case since traditionally Medicaid will reimburse only about two-thirds of what a Medicare similar kind of service would do. And then Medicaid has even less support for the services that have to do with prevention and attention to quality services like health promotion.

The latter part of the week we were at the hospital of the University of Pennsylvania in the Adolescent Family Planning Services Clinic, where we were providing services to girls under 17 years old who were seeking family planning. It was discouraging in a lot of ways because of, certainly, the very young age of these women, the majority of whom presented with one or more sexually transmitted diseases that needed to be treated that day. Some of them were already moms, sometimes twice.

The kind of attention that needed to be given them took a lot of time because they were reticent at times to give the information that we required in order to help them. Sometimes, although they presented with a particular complaint, it turned out that their real fear was that their most current boyfriend had tested positive for AIDS and they didn't know what to do about that, where to go for help, and who to talk to. Or they just came in seeking family planning services to discover that, in fact, they were already pregnant and weren't sure how they were going to deal with that with their families.

These visits certainly take a lot of time, they take a lot of expertise on the part of the care provider, and yet they're often not evaluated at the level of reimbursement that they need to be in order to make them cost effective.

What we would like to encourage you to consider in any of the plans that you decide upon, is to make sure that health promotion types of services are always going to be accentuated in the policies that you develop. And also that nurse-midwives and other nurses practicing in extended roles will receive recognition for the services that they provide. Also that when demonstration projects are shown to be cost effective, as compared to traditional care services, that they be supported and be placed in the areas where they most clearly can make a demonstrated effort and result. Certainly the kind of health care that we were providing for those teenagers needs to be available to them, perhaps even closer to their school or their home situation so that they can make it available to themselves before they, in fact, have trouble or have problems that need specific treatment.

I appreciate the opportunity to talk to you today and would be happy to receive any questions that you may have.

[The prepared statement of Ms. Higgins follows:]

AMERICAN
COLLEGE OF
NURSE-MIDWIVES

TESTIMONY

"Options in Access to Health Care"

Presented by

Kathleen M. Higgins, CNM, MSN

Before
The Pepper Commission

Chairman: John D. Rockefeller, IV

October 24, 1989

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Mr. Chairman, my name is Kathleen M. Higgins, CNM, MSN. I am a certified nurse-midwife currently in active practice in Philadelphia, Pennsylvania, and I am pleased to appear before the Commission on behalf of the American College of Nurse-Midwives (ACNM). We appreciate the interest that the Commission has shown about the need to take additional steps to combat infant mortality by improving access to prenatal care and other needed health care services for high-risk women and their babies.

A certified nurse-midwife (CNM) is a registered nurse with advanced education in midwifery who cares for women throughout their lives. This involves the provision of care for women and their newborns not only during pregnancy, childbirth, and the postpartum/neonatal period, but also includes family planning and gynecological services for women of all ages. CNMs work collaboratively with physicians with whom they consult and to whom they refer patients who develop complications that require physician care.

The members of ACNM are very familiar with the health access problems of many American women. Much of the care provided by CNMs has always been directed at the needs of those women who have special problems in obtaining childbearing and other health services. Nurse-midwives are especially proud of their record in caring for pregnant women who are at risk for developing health problems because of various social and/or economic considerations. Pregnant teens in the inner-cities, young mothers in underserved rural areas of the country, Hispanic women in border States, native

Americans on reservations, and minorities seeking help from clinics are all clients served by midwives in daily practice.

It is the expressed policy of the ACNM that all Americans have some form of comprehensive health benefit coverage, including adequate protection against the costs of health care needed by mothers and their children during and after pregnancy and during early childhood as well. Obviously, we recognize that the problems of the uninsured and underinsured extend well beyond the care needs of women and infants. But, until the need of these women and children are addressed, steps to effectively combat infant mortality in America will be impaired.

The College has long been a major advocate of Congressional efforts to expand Medicaid eligibility requirements for low-income women and children as one important way to improve access to pre-natal and maternity care. We have been especially encouraged about recent legislation that makes it possible for States to greatly enhance Medicaid eligibility for these particularly vulnerable individuals. Nevertheless, the College believes that other actions are also needed, if access to needed are is to be assured.

One of these steps, which was recommended by the National Commission to Prevent Infant Mortality, calls for an increase in the number of health care providers, willing and able to serve the needs of low-income women and who are at a greater than average risk for their pregnancies. Expanded eligibility for needed care alone will not assure that all those with the need for services before, during and after pregnancy can actually find providers who are able to help them. Thus, ACNM believes that other steps need to be taken -- in addition to improved benefit coverage -- to encourage wider practitioner participation in programs like Medicaid.

There are several interrelated reasons why there is a lack of an adequate supply and better distribution of primary care professionals to meet the needs of low-income women. We agree with the Commission to Prevent Infant Mortality that one major problem is the availability and cost of professional liability insurance for practitioners who engage in obstetrical practice. Undoubtedly, the professional liability problems of the last few years has had a negative impact on the willingness of some professionals to service low-income, high-risk patients and caused them to limit or drop altogether their obstetrical services and participation in critical publicly-financed programs like Medicaid. Moreover, some providers seem to feel, correctly or not, that high-risk patients also represent potentially higher than average risks or litigation.

Just a few days ago, the Institute of Medicine (IOM) of the National Academy of Sciences released its report on problems with availability of obstetrical care in the United States stemming from malpractice litigation and liability insurance costs. The report documents the large number of obstetricians, family practitioners and certified nurse-midwives "leaving, or limiting, their practices in order to avoid the threat of litigation." The IOM report urges a variety of responses by the States to these issues, and calls on the Federal Government to support demonstration projects that would test innovative approaches to the professional liability problem.

The College also believes that something must be done to address the adequacy of current payment levels for services now provided to low-income and other uninsured individuals. For example, Mr. Chairman, many Medicaid programs have a long history of generally low payment rates for practitioner services in general, and especially for important primary care services. One Subcommittee in the House of Representatives that has looked in detail at this problem reports that, on average, Medicaid payment rates are only about two-thirds of the Medicaid rates for comparable services. Medicare rates, of course, are frequently lower than those generally charged by practitioners in the communities in which they practice.

Unless payment rates for services to low-income patients are reasonably related to the costs that practitioners incur, many practitioners simply cannot afford to cover their liability and other practice expenses. It seems to us that, if policymakers are serious about steps to improve access, real efforts must be made to attract wider participation by the providers who can deliver the care needed. Among the steps required is an improvement in payments for primary care services, including for the services of physicians and nurse-midwives. Some of the practitioner payment reform steps now being discussed by Congress for the Medicare program -- if likewise applied to state Medicaid programs - could be very helpful in this area.

Finally, we recommend that other programs are needed to develop cost-effective alternatives for meeting the needs of high-risk women. These programs should bring services directly to the high-risk populations in the communities where they live. Ambulatory care centers that offer pre-natal care services in an organized system could be made more conveniently available and attractive to patients -- especially where other alternatives do not exist. The scope of the services provided should also extend to gynecological care for young women to bring them into contact with health care professionals -- including nurse-midwives, who could counsel them about the effects of undesirable, high-risk behavior on pregnancy and infant health.

We appreciate your interest in our views about options for improving access to quality health care for every American.

Chairman ROCKEFELLER. Thank you very much, Ms. Higgins. Paul Rettig.

STATEMENT OF PAUL C. RETTIG, EXECUTIVE VICE PRESIDENT, AMERICAN HOSPITAL ASSOCIATION

Mr. RETTIG. Thank you, Mr. Chairman. I'm Paul Rettig, executive vice president of the American Hospital Association. I am pleased to have the opportunity to testify before the Pepper Commission on behalf of our nearly 5,500 member institutions and more than 48,000 personal members. We want to indicate our support for you in the difficult task you have undertaken, to find some solution to the problem of the uninsured and people needing help with long-term care.

You are familiar with the statistics regarding the uninsured, but it's at the level of the individual hospital that we meet up with the individual people that the statistics represent. As the witness from the National Medical Association has already said, these people tend to seek too little care, too late. They come to deliver their babies, but not to receive prenatal care. They come to emergency rooms with serious illnesses that could have been treated less expensively and more effectively a year earlier. And they come after they have depleted their economic resources to pay for care, thereby assuring that they will have no resources to use in recovering from the financial devastation of illness.

As you know, the situation has worsened from several factors: The deterioration of the traditional link between employment and insurance; the recent deterioration of the Medicaid Program over the last 10 years, so that its current coverage is less than 40 percent of those below the poverty level; and, finally, the inadequacy of both private and Government coverage for long-term care for people who are elderly, disabled, or chronically ill.

Society has called on hospitals to care for the ill and injured, and we want to report that we are attempting to do our part. In 1988 alone hospitals provided more than $8 billion in unsponsored care. But with increasing frequency, hospitals are finding themselves unable to find the resources to do this.

You're all familiar with the payment reductions that have occurred in Government programs over the years. We are now at the point where we believe that while quality and access have been maintained, they are further threatened. In fact, the safety net in the case of hospitals is woven out of cost shifting, you might say, and it's beginning to break down as all payers are increasingly rigorous in trying not to pay for anybody else's patients. The logical conclusion of that, is that those who cannot pay should pay and cover their own costs, because no one else will.

As to the cost problem, we are seriously aware of this concern, but we point out that overall hospital expenses since 1982 have remained steady as a percentage of the gross national product at about 4.3 percent. In terms of, at least, the gross national product, hospitals have remained constant.

We strongly support action from both public and private sectors to deal with the twin problems you're attempting to wrestle with. We believe that both Federal mandates and tax incentives and other subsidies should be used to make employer-provided insurance available to all workers. We believe that there is need for reform in Medicaid eligibility policy, enrollment incentives, financing and reimbursement, and service coverage to help the Federal Government meet its obligations to those who cannot afford insurance. And we believe in the sharing through both public and private sectors of the responsibility to assist Americans in providing for their long-term care needs.

Making sure that all Americans have access to care should be the fundamental goal of Medicaid and a national minimum eligibility floor for Medicaid would assure such access for the Nation's neediest citizens. Other reforms are needed in areas of enrollment incentives, financing, reimbursement, and coverage policies.

We believe all employers should offer a minimal health care plan to all their workers and their families, just as they must provide a minimum wage and a safe environment. If coupled with the kinds of incentives and subsidies necessary to enable employers to comply and if coupled with strong Medicaid reforms, the national mandate for employers would go a long way toward assuring that all Americans secure access to timely, cost-effective, quality care.

The American Hospital Association's recommendations concerning both care for the medically indigent and long-term care call for a combination of public- and private-sector initiatives. These are outlined in some detail in the lengthier statement that has been submitted to you. The private-sector initiatives would be funded through premiums paid by both employees and employers. The public-sector initiatives would be funded through a combination of broadly based taxes and premiums. Realistically, the principal source of funding for public-sector programs would be higher taxes.

Finally, we hope that in addressing the Nation's health care concerns, this Commission will give careful consideration to the long-term consequences that yearly budgetary decisions are beginning to have on the delivery of health care services. Just by way of illustration, for example, in fiscal year 1987 there were three different payment rates for hospitals, and it appears that this fiscal year will be a similar situation. We recognize the importance of reducing the Federal deficit, but we believe hospitals have already contributed disproportionately to the effort.

Somehow in your work you need to come to terms with the annual budget effort and its impact on the sensible planning of health care programs. We applaud your efforts so far to address these problems and urge your continued attention. And we stand ready to assist you in any way we can. Thank you for the opportunity to appear.

[The prepared statement of Mr. Rettig follows:]

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Statement of the American Hospital Association before the Pepper Commission on Access to Health Care

October 24, 1989

SUMMARY

The growing number of uninsured and underinsured Americans presents a major challenge to private- and public-sector health policymakers. The problem has its origins in:

- The erosion of the traditional link between employment and insurance, which has led to employers covering a shrinking proportion of workers and their families;
- The recent deterioration of the Medicaid program, which now covers less than 40 percent of those below the federal poverty level--down from 65 percent a decade ago; and
- The inadequacy of private insurance for or government-sponsored coverage of long-term care.

This crisis calls for immediate, strong action from both the public and private sectors. The American Hospital Association (AHA) recommends:

- Combining federal mandates and tax incentives and other subsidies to make employer-provided insurance available to all workers;
- Reforming Medicaid eligibility policy, enrollment incentives, financing and reimbursement, and service coverage to help the federal government meet its obligations to those who cannot afford insurance; and
- Encouraging a public- and private-sector sharing of responsibility to assist Americans in providing for their long-term care needs.

The American Hospital Association's recommendations concerning both care for the medically indigent and long-term care call for a combination of public- and private-sector initiatives. The private-sector initiatives would be funded through premiums paid by both employees and employers. The public-sector initiatives would be funded through a combination of broadly based taxes and premiums. Realistically, the principal source of funding for public-sector programs would be higher taxes.

INTRODUCTION

Mr. Chairman, I am Paul C. Rettig, executive vice president of the American Hospital Association. I am pleased to have the opportunity to be here today on behalf of the AHA's nearly 5,500 member institutions and more than 45,000 personal members to discuss the issue of access to health care in the United States and the problems resulting from the lack of health insurance coverage.

When we debate issues such as health care, we tend to get caught up in technical jargon, in facts and figures. But that is not what this debate is about or why this commission was created. We must not forget that discussions of health care are about real people and their right to have access to affordable, high-quality health care. Though this testimony cannot directly focus on those real people, we hope it will contribute to the commission's development of a workable plan to provide health care for all Americans. In that context, I am also here today on behalf of millions of individuals, especially those who do not enjoy the access to care most of us take for granted.

Nationally, 37 million Americans are medically uninsured, millions more are underinsured, and the number of medically indigent grows every year, in good economic times as well as bad. Hospitals strain to meet the needs of the medically indigent, with the current bill for indigent care services topping

$7 billion annually. Although the uninsured eventually receive care, they tend to seek too little care, too late. They come to deliver their babies, but not to receive prenatal care; and they come to emergency rooms with serious illnesses that could have been treated less expensively a year sooner. They come to us after they have depleted their few economic resources to pay for care, thereby assuring that they will have no resources to recover from the financial devastation of illness.

Much of the rise in the number of uninsured has been caused by the recent deterioration of Medicaid coverage. Medicaid covers less than 40 percent of the poor population; a decade ago it covered 65 percent. But much of the problem of medical indigence also stems from the erosion of the traditional link between work and insurance; employers have been covering a shrinking proportion of workers and their families.

For this reason, AHA's Special Committee on Care for the Indigent concluded two years ago that an enduring solution to the problem of medical indigence will require initiatives by both the public and private sectors to:

- Reduce the size of the medically indigent population through private health insurance; and
- Finance care for the medically indigent who are unable to obtain private insurance through restructured and extended public programs.

Another dimension of the health care access problem is long-term care as it relates to the elderly, the disabled, and the chronically ill. The Medicare Catastrophic Coverage Act of 1988 focused the nation's attention on problems faced by Medicare beneficiaries and underscored shortcomings of current public and private financing of long-term care. With Congress poised to drastically curtail, if not repeal that Act, the problem of financing long-term care only looms larger. The responsibility for its solution must be shared by all: individuals, the private sector, and state and federal governments.

HEALTH INSURANCE COVERAGE OF THE EMPLOYED

The U.S. health insurance system is currently built on employer-provided insurance. About 85 percent of the 191 million privately insured Americans now receive insurance through the workplace; federal and state tax policies clearly support this pattern. In 1982, federal and state governments provided a $31 billion subsidy of the privately insured through exclusion of employer-paid health insurance from the taxable income of employees.

Nevertheless, nearly 88 percent of the uninsured were either themselves workers or lived in families of workers. A recent analysis by the Employee Benefits Research Institute shows that, of the 37 million non-elderly uninsured in 1986:

- 48 percent lived in families headed by full-year, full-time workers;
- 8 percent lived in families headed by full-year, part-time workers;
- 22.1 percent lived in families headed by sometimes unemployed workers;
- 9.5 percent lived in families headed by part-year workers; and
- Only 12.4 percent lived in families headed by non-workers.

In combination, these statistics lead to two conclusions. First, the favorable tax treatment of health insurance benefits has facilitated high levels of private insurance coverage. Second, even current tax incentives are inadequate to induce a sizable number of employers to offer private insurance coverage through the workplace.

There is considerable logic to the idea of extending coverage to many of these people by building on the existing system. The key policy question is how. Two approaches have been suggested: the use of mandates and the use of tax supports, public subsidies, and other incentives. Both approaches are necessary.

Ideally, AHA would prefer to rely on strong economic incentives and joint private-/public-sector action to induce employers to offer insurance to their employees. Many state and local groups are currently experimenting with many bold initiatives designed to facilitate coverage by lowering, and often partially subsidizing, the cost of insurance.

But strong economic incentives and joint private-/public-sector action are no longer enough. The growing "crack" in the private and public insurance system has now become an abyss. This crisis calls for immediate, strong action from public programs and the private sector. Yet this outcome is unlikely without a federal mandate. Just as employers must provide a minimum wage and a safe working environment, they have an obligation to make health insurance available to their employees. Federal mandates should be used to promote private insurance through the workplace.

Workable Mandate

For a mandated approach to work, employers must have the tools to comply. A workable mandated approach will require carefully defined mandates to minimize economic dislocations. Essential elements of a workable mandate are:

- All employers should be included, although the time frames and mechanisms for implementation may vary depending on the business's size and stage of development and the problems experienced by small employers or those that are financially distressed.
- All employees (except temporary employees) and their dependents should be covered.
- Mandated insurance should cover all expenses (other than required cost sharing) for "reasonable and medically necessary" acute care, including acute psychiatric and rehabilitative care, prenatal and well baby care, and any other preventive care services that are proved cost-effective. The mandate should allow out-of-pocket expenditures up to a specified, indexed dollar amount per year.
- Employers should make a significant contribution (at least 50 percent) to the premium, with the contribution prorated for part-time permanent employees based on the number of hours worked.
- The public sector should work with the private sector to assure that

affordable insurance is available through risk pooling arrangements. To provide time for the development of these mechanisms, the mandate should be phased in over a period of no more than five years and should be combined with special tax incentives and/or the use of special hardship funds to ease the burden for employers who, because of their size or financial status, might find compliance particularly difficult.

- Employees of non-complying employers would be enrolled in an appropriate state offered plan, and the employer would be assessed a fee to cover the premiums plus a penalty.

- States should retain authority to regulate insurance, and may require insurers to offer additional benefits, but would not be permitted to require employers or employees to buy them.

AHA supports the concept of federally mandated health insurance coupled with incentives to ease the burden of compliance, as embraced by The Basic Health Benefits for All Americans Act (S.768/H.R.1845). Insurance should be a requirement for doing business, in much the same way that paying a "minimum wage" is a condition of doing business in the United States. Although some have opposed mandates on the grounds that they would impose a substantial burden on business, it must be recognized that all Americans pay the cost of inadequate insurance protection. And big businesses, among which private insurance is nearly universal, pay three times: once for their own employees, once for working spouses of those employees, and once for those who are not insured, in the form of higher prices for medical care.

Any feasible mandated insurance program must be a partnership effort by employers, employees, and government within the context of the broader goal of universal access to health insurance. Mandating insurance coverage is a major step toward ensuring access to care and the equitable distribution of the cost of medical indigence. Employer mandates, however, are only part of the answer to medical indigence. If business has an obligation to make insurance available for employees and dependents, government has the obligation to create an environment that will enable business to comply. AHA urges Congress to strengthen tax incentives to encourage both individuals and small employers to obtain health insurance coverage and to make such insurance coverage affordable.

One such incentive would be to allow owners of unincorporated businesses to deduct 100 percent of health insurance costs for themselves and their families. Among small businesses with fewer than 10 workers, only 29 percent of unincorporated "proprietorships" (compared with 70 percent of small corporations) offer a health plan, in part because owners of unincorporated businesses are permitted to deduct only 25 percent of health insurance costs for themselves and their families as a business expense. Legislation (S.494 and S.1168) has been introduced permitting the 100 percent deduction already enjoyed by owners of incorporated businesses.

States also should support private insurer, employer, and provider efforts to develop alternative sources of affordable insurance. Among the options that should be explored are the formation of multiple-employer insurance arrangements and the development, with providers, of financing and delivery systems to effectively manage utilization and costs.

MEDICAID REFORMS

Even if these actions are taken, it is clear that the government will have to continue playing a major role in ensuring that health care services are available to all Americans. As such, public programs to finance care for the medically indigent who are unable to obtain private insurance should be restructured and extended. It is imperative that the federal government fulfill its obligations under existing programs, particularly Medicaid.

AHA supports the expansion and revision of the Medicaid program into a separately funded and administered program with three distinct parts:

- Acute care coverage for the medically indigent not eligible for Medicare;
- Supplementary acute care coverage for Medicare beneficiaries; and
- Long-term care coverage for low-income individuals.

Despite recent expansions of state options, the program fails to cover many of the most vulnerable groups. The Medicaid program is covering fewer poor individuals than ever before. Congressional Budget Office data, for example, show that among unmarried working mothers earning under $3.50 an hour, or about $6,700 a year:

- 24 percent are covered by employers and other private coverage;
- 31 percent are covered by Medicaid; and
- 45 percent are uninsured.

The inadequacy of the Medicaid program is the primary reason for the gap in insurance for children, particularly poor children. Inadequate Medicaid coverage for individuals with AIDS is another area that deserves attention. These problems could be addressed by requiring or facilitating reform in eligibility policy, enrollment incentives, financing and reimbursement, and service coverage.

Congress enacted the Omnibus Budget Reconciliation Act of 1986 (OBRA 1986) and the Omnibus Budget Reconciliation Act of 1987 (OBRA 1987) that gave states options to expand Medicaid eligibility for the very vulnerable--poor mothers and young children. The Medicare Catastrophic Coverage Act currently requires states to cover pregnant women and infants up to 100 percent of the federal poverty level. Through these pieces of legislation, Congress has demonstrated its commitment to assist those most in need and has begun to repair much of the damage caused by the earlier erosion of Medicaid coverage of the poor. Congress is currently deliberating incremental improvements in the Medicaid program in the context of the FY 1990 budget reconciliation measure, but despite these possible changes severe eligibility problems remain, and the program faces significant problems with payment, reimbursement, and service coverage.

Eligibility

Under current law, states are required to cover only pregnant women and infants. For older children, OBRA 1986 and OBRA 1987 offer options rather than mandates. Whether a particular poor child is covered, therefore, will depend on whether the state has chosen to exercise the option and how aggressively the state chooses to be in its outreach efforts. While Congress is likely to expand mandatory coverage for children, the expansion will be limited.

Eventually, we must come to terms with the core problem: Medicaid eligibility ceilings are linked to Aid to Families with Dependent Children (AFDC) payment levels, and these AFDC payment levels, in turn, show both tremendous interstate variation and a consistent decline over time. In 21 states, eligibility levels are now at or below 50 percent of the poverty level, meaning that dependent children and their mothers in three-person families earning more than $4,650 a year do not qualify. (Medically needy programs in some of these states raise the income ceiling somewhat, but never by more than one-third.) As a solution to this problem, AHA supports decoupling Medicaid from cash assistance programs and moving toward federal financing of Medicaid with uniform eligibility standards and coverage.

In the interim, we support:

- Establishing a minimum national eligibility floor for Medicaid, set at 100 percent of the federal poverty level, providing for an orderly phase-in for moving the national floor to 100 percent of poverty.
- Mandating coverage of pregnant women and infants up to 185 percent of the poverty level, phased in over three years.
- Phasing-in mandatory coverage of children in families with incomes below 100 percent of poverty.
- Establishing a program to "buy in" to Medicaid for the near poor whose incomes exceed Medicaid eligibility ceilings.

Eligibility Determinations

Many Medicaid applicants must comply with complex eligibility procedures for income determination. At present, a sizeable number of the poor are needlessly uninsured. They are eligible for Medicaid coverage but not, in fact, enrolled, largely because proving their eligibility is too complicated and burdensome. A study of the AFDC/Medicaid eligibility process in 17 southern states was conducted by the Southern Governers' Association. It found almost two-thirds of the denials were due to applicant failure to comply with procedural requirements. In southern states studied, denial rates in FY 1985-1986 ranged from 77 percent in Texas to 19 percent in North Carolina.

The full potential of Medicaid coverage for the poor cannot be realized unless there are uniform, simple procedures for eligibility determinations. AHA supports:

- Modifying the application of the asset test for determining eligibility.
    - Mandating elimination of the assets test for pregnant women and children.
    - Permitting states, on an optional basis, to eliminate the assets test for selected other groups.
    - Permitting states, on an optional basis, to use the SSI asset test or a test no more restrictive for determining eligibility. (This would allow states to eliminate the restrictive AFDC test.)
- Broadening the presumptive eligibility option to apply to ambulatory services for children as well as pregnant women.

- Requiring HCFA to establish model requirements to assure that states' procedures are not excessively complex or burdensome.
- Clarifing that state/provider cooperative arrangements to assist individuals in the eligibility application process are to be encouraged. Such arrangements would allow state eligibility workers or hospital personnel to assist Medicaid applicants and make eligibility determinations at the hospital site or at an outreach facility.

The eligibility determination process should be efficient and economical, enrolling those who meet the eligibility criteria, and keeping out those who do not. At present, a sizable number of the poor are needlessly uninsured. They are eligible for Medicaid coverage but not, in fact, enrolled, largely because proving their eligibility is too complicated and burdensome. State and federal initiatives to expand coverage are hampered by unreasonable or excessive administrative requirements. The use of strict assets tests and the practice of assessing financial penalties against states for erroneous enrollments (but not for erroneous exclusion of eligibles) contribute to the use of long and complex application forms, which, in turn, discourage many eligibles from completing--or even starting--the application process. The full potential of Medicaid coverage for the poor cannot be realized unless there are uniform, simple procedures for eligibility determinations.

Potentially, hospitals can play an important role to help close this enrollment/eligibility gap through outreach activities. AHA is strongly committed to supporting hospitals in this activity and will provide technical assistance to hospitals and other organizations wishing to play this role.

Adequate Reimbursement

Current Medicaid law requires states to assure that payment for inpatient hospital services:

- Be reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities meeting quality standards; and
- Provide reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality.

States and the Department of Health and Human Services increasingly have shirked their duty to assure adequate payment. A recent study of Medicaid payments for Michigan hospitals revealed that hospitals were reimbursed for only 86 percent of their inpatient treatment costs and only 70 percent of their outpatient costs. For the state of Illinois, estimates are that the Medicaid program underpays hospitals by 35 percent. Inadequate payment levels threaten access to high-quality care for Medicaid recipients. With reimbursement in many states falling short of actual costs, many hospitals have mounted court challenges to these state reimbursement policies.

In the state of Colorado, the U.S. Court of Appeals for the 10th Circuit rejected an attempt by the state to reduce Medicaid payment rates by 46 percent because of shortfalls in state funds, finding that the state violated federal law and regulation. In the Commonwealth of Virginia, the hospital association has challenged the state's reimbursement plan for hospitals on grounds that federal law has been violated in Baliles v. Virginia Hospital Association. The U.S. Supreme Court recently announced its decision to review the case, a decision that will doubtless have major implications for states and their hospitals.

Further complicating the issue of adequate reimbursement is current HCFA policy to apply to Medicaid an upper payment limit tied to Medicare reimbursement levels. In applying this policy, HCFA's emphasis has not been whether payments are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated facilities, but rather that Medicaid payments do not exceed amounts that would have been paid under Medicare for similar services. The basis of HCFA's authority to apply such limits has been continually disputed by congressional panels with authority over the Medicaid program.

To fortify the federal government's commitment to assuring adequate payment for services provided to Medicaid beneficiaries, the American Hospital Association urges:

- The HHS Secretary be required to clearly articulate the criteria by which adequacy of Medicaid rates are measured; and
- The Secretary of HHS be prohibited from limiting Medicaid payments to hospitals on an aggregate to the estimated amounts that would have been spent under Medicare.

Service Coverage

Because Medicaid is a joint federal-state program, with states free to operate within general federal guidelines, state programs can and do vary considerably not only on the extent but also on the content of coverage. Federal rules on covered services mandate certain services for the categorically needy and a different list for the medically needy; they leave other coverage decisions to states' discretion. Moreover, the law permits states to limit the amount or scope of required as well as optional services.

This patchwork Medicaid system results in gaps and voids in which necessary and cost-effective services are not covered. In particular, this system often makes it difficult for states to implement cost-effective mechanisms for addressing the catastrophic and chronic care needs of population groups such as children or individuals with AIDS.

State Medicaid plans have the option of paying for case-management services and may choose to target these services to select groups of patients, based on diagnosis or condition. But, Medicaid traditionally has not paid for case-management services, or for many of the support services necessary to maintain a disabled child or an AIDS patient in the community. There have been some recent positive developments along these lines, however, and we believe this progress could be accelerated through additional steps taken by Congress.

AHA supports providing an enhanced federal match of 80 percent for the selected case-management option to encourage more cost-efficient and cost-effective utilization of health care services.

The use of swing beds is another delivery option. Under current Medicaid law, states have the option of covering swing-bed services in hospitals approved under Medicare's swing-bed provisions. Long-term care provided through a swing bed in a hospital promotes continuity of care. Patients benefit from swing-bed care in the hospital as part of a full continuum of care: when acute care services are inappropriate, when the patient cannot go home, or when the patient is unable to enter a nursing home. Swing beds--in both urban and rural hospitals--are an appropriate response to shortened lengths of stay and efficient use of bed capacity encouraged by all purchasers of health care services.

AHA recommends that states be required to cover swing-bed services under Medicaid and that geographic and bedsize limits be removed as criteria for swing-bed usage.

States have shown great success in using a waiver option (Sec. 2176) for disabled children and adults alike, which allows for provision of home- and community-based services to Medicaid recipients who otherwise would require institutional care. However, only three states with the 2176 waiver specifically target home- and community-based services to individuals with AIDS. Many states have been reluctant to seek a waiver because of the difficulties involved: they must prove that the estimated home care costs are lower than estimated institutional costs, and they also face limits in terms of the total number of people who can be served under a waiver.

Given the proven cost effectiveness of community-based care for many groups currently receiving expensive institutional care under Medicaid--AIDS victims and the elderly, as well as disabled or chronically ill children--Congress might wish to consider replacing the 2176 waiver provisions with a straightforward state option allowing for such substitutions.

Any comprehensive approach to the problem of medical indigence must begin with Medicaid reform--reform not only of state eligibility standards but of payment, reimbursement, and coverage as well. We have seen some important gains in the past few years, but much remains to be done.

MEDICARE

No plan for ensuring access to high-quality care will be complete without improving the adequacy and equity of Medicare prospective payments. In recent years, Medicare hospital payments have borne much of the brunt of federal deficit reduction.

Recent Medicare proposals have seemed more driven by a desire to reduce federal outlays than a commitment to fulfill the promise of providing access to high-quality health care services for the nation's elderly. Since the program's inception in 1983, there is more than a 13 percentage point disparity between total increases in the payment rate and corresponding increases in the prices hospitals must pay for goods and services The disparity between PPS rates and the payment update caused the average hospital operating margin for Medicare to approach or reach zero in 1988 based on

HCFA's accounting methods. By 1989, more than 50 percent of all hospitals are projected to suffer loses treating Medicare patients.

Medicare payment shortfalls have forced the closure of trauma centers, emergency rooms, other specialty services, and some hospitals in total. Further cuts of this magnitude are a direct threat to hospitals' ability to maintain access to the high-quality care Medicare beneficiaries and others expect and deserve.

AHA believes there should be no further cuts in Medicare payments to hospitals, and until there is a more equitable way to pay for indigent care, it is vital that the disproportionate-share adjustment be maintained and adequately funded. Furthermore, additional funds are needed to improve the adequacy and equity of Medicare payments to hospitals so that hospitals can fulfill their mission and meet future health care needs.

AIDS

The impact of AIDS on the U.S. health care system has been steadily growing and will have a dramatic, unforeseen impact on the entire health care delivery system. More than 100,000 AIDS cases have been reported to the Centers for Disease Control. By the end of 1992 the number could reach 365,000. Though projected hospital costs per case have fallen from $140,000 three years ago to between $25,000 and $50,000 today, the growing number of AIDS and AIDS-related-complex patients with no health insurance drains government resources. Excluding federal Medicaid matching funds for AIDS care, state outlays are projected to jump to $123.6 million in FY 1988 from $9.3 million in FY 1984. (Medicaid pays for the health care costs of 40 percent of AIDS patients.)

AHA believes that care for AIDS patients and those with other HIV-related illnesses should be financed by the current pluralistic system of private and public funding, with financing reforms as summarized in other sections of this testimony. Responsibility for the care of AIDS patients should be shared by a wide variety of providers to promote community-based care and to lessen the potential cost burden faced by any one institution.

LONG-TERM CARE

Even with the provision of a minimum amount of health care coverage, thousands of families will still be faced with the threat of financial disaster should they face a catastrophic illness or injury. The Catastrophic Coverage Act of 1988, should it survive, fails to adequately address the potential for financial ruin that can result from long-term care needs.

The responsibility for financing long-term care should be shared by all segments of society. We must encourage individuals to provide for their long-term care needs to the extent permitted by their income as a way to shield themselves from catastrophic expenses of chronic illness. In addition, we must ensure access to long-term care when individual resources are inadequate and establish a more humane alternative to "spend down" requirements as a precondition for eligibility under public programs. People should not have to dissipate limited assets to qualify for government assistance.

AHA recommends a system of combined private and public funding that encourages individuals to provide for their own long-term care as much as possible and that ensures access to needed long-term care when individual resources are inadequate. Specific recommendations include:

- A separate program of Medicaid long-term care coverage for those needing assistance. AHA does not, however, support a government-funded program to provide long-term care for everyone.
- The development of alternatives to the current Medicaid "spend down" requirements to prevent further impoverishment of the dependents of those with chronic illness. AHA supports a system of federal and state loans as an alternative to "spend-down" requirements for Medicaid eligibility.
- The development of private-sector alternatives for financing long-term care, encouraged through tax incentives and demonstration projects. AHA supports the use of pre-funding mechanisms such as medical savings accounts and private long-term care insurance.
- An increased emphasis on public programs that offer alternative methods of delivering care that, when appropriate, can keep those with chronic illnesses out of institutions.
- Closing the gaps in Medicare coverage of extended care services, including home health, skilled nursing, rehabilitation, and hospital-based transitional care services, and expanding eligibility to all beneficiaries below the federal poverty line. Continued focus on

skilled nursing care is needed in light of likely repeal of the expanded skilled nursing benefit in the Catastrophic Coverage Act. AHA recommends elimination of the three-day prior hospitalization rule for access to extended care services in skilled nursing facilities.

- The case-management option should be encouraged for long-term care because it can help minimize more costly inpatient care and improve quality by promoting better coordination of services and greater use of alternatives to institutional care.

COST CONTAINMENT AND QUALITY ASSURANCE

Hospitals have played a major role in health care cost containment. Medicare hospital payments have been reduced from 73 percent of total Medicare outlays in 1982 to 64 percent in 1988. Despite the aging of the population and the steady introduction of costly new technology, overall hospital expenditures have remained virtually constant at 4.3 percent of GNP since 1982. At the same time non-hospital hospital personal health care spending rose from 4.3 percent of GNP in 1980 to 5.6 percent in 1987.

Between 1983 and 1986:

- The number of hospital admissions dropped more than 3.7 million, or more than 9 percent;
- Licensed beds decreased 60,000, or more than 4 percent of total beds nationwide; and

- Average length of stay at hospitals fell 6.5 percent.

While the best efforts of the hospital field have and will continue to be focused on controlling costs, hospitals have provided an increasing amount of care for the uninsured. In 1988 alone, hospitals provided more than $7 billion dollars in unsponsored care. But hospitals are finding it harder to carry the financial burden of unsponsored care. Not only is the hospital safety net--woven out of cost shifting--unraveling as private payers refuse to contribute to unsponsored care, but the overall financial stability of hospitals is eroding as government increasingly pays them less than it costs to deliver care to Medicare beneficiaries and Medicaid recipients.

Society has called on hospitals to care for the ill and injured, regardless of payment considerations and regardless of how expensive the care may be. For their part, hospitals respond by serving all in need. But with increasing frequency, hospitals are beginning to lack the resources required to meet this challenge. The past five years have seen substantial reductions in hospital funding. Despite these reductions, hospitals have struggled to maintain their commitment to delivering high-quality care for the nation's ill and injured. Quality and access have been maintained, but both are threatened by further cuts. Hospitals need adequate and equitable payments, with which they fund patient care.

AHA hopes that in addressing the nation's health care concerns, this commission will give careful consideration to the long-term consequences that yearly budgetary decisions are beginning to have on the delivery of health care services. The chaos of constantly changing and inadequate payment policies has precluded hospital managers from undertaking effective financial planning. For example, in FY 1987 alone there were three different payment rates and it appears that FY 1990 will be similar.

Although controlling costs is of paramount importance, it cannot be done without ensuring the continued quality of care. AHA is working to help hospitals and their medical staffs assure that Americans continue to receive the high-quality health care services they expect and deserve. AHA's Hospital Research and Education Trust is presently engaged in the Quality Measurement and Management Project (QMMP). In addition to developing a model for integrated quality assurance in hospitals, QMMP is developing a data reporting system that can be used by hospital managers to evaluate and improve their own clinical performance.

AHA strongly supports effectiveness research as a tool for defining what care is appropriate, efficient, and necessary. The need for effectiveness research is widely recognized. It has long been thought that a significant level of inappropriate, inefficient, or unnecessary services are provided each year. More than a decade ago, epidemiologist John Wennberg, M.D., revealed wide variations in the use of certain medical interventions among comparable populations without a demonstrably different impact on health status. Researchers do not understand why this variation exists, but Dr. Wennberg has suggested that greater variation exists for conditions about which there is a lack of consensus among clinicians about what works best. In recent years, using explicit practice guidelines developed by expert panels, researchers have found that large percentages of certain tests and procedures are performed inappropriately, i.e., without sufficient clinical justification. Effectiveness research will:

- Clarify which interventions work best and under what circumstances (for what patient conditions);
- Produce clinical practice guidelines or standards of what constitutes appropriate care so as to furnish hospitals and physicians with a means by which they can monitor and modify their own performance;
- Give us a more realistic view of what services can and cannot be eliminated;
- Help to assure that those who need services will get services; and
- Provide some guidance for external review mechanisms that now seek in relative ignorance to distinguish the appropriate from the inappropriate.

FINANCING EXPANDED BENEFITS

The AHA's recommendations concerning both care for the medically indigent and long-term care call for a combination of public- and private-sector initiatives. The private-sector initiatives would be funded through premiums paid by both employees and employers. The public-sector initiatives would be funded through a combination of broadly based taxes and premiums. Realistically, the principal source of funding for public-sector programs would be higher taxes.

The Special Committee that developed the recommendations on ensuring access for the medically indigent, as noted above, called for a basic restructuring of the Medicaid program. The component of the program that would finance care for the medically indigent who are not eligible for Medicare would be financed through a broadly based tax. Such a tax might take the form of a general income tax or a broadly based dedicated tax such as a special payroll tax. In its report, the Committee recommended that any such tax be structured to provide a strong positive incentive for employers to offer--and their employees to obtain--private health insurance coverage. Such an incentive could be readily incorporated in a dedicated payroll tax. For example, a payroll tax of 2 percent, equally divided between employers and employees, could be established as the basic source of funding for an expanded Medicaid program. Those employees who obtain private insurance would be forgiven one half of this tax, leaving each with a liability of only one-half of 1 percent.

Although raising taxes is never popular, neither is the prospect of millions of Americans continuing to live with the uncertainty of how to pay for the costs of serious illness. The advantages of a broadly based financing system such as that described by the AHA Committee are threefold:

- It achieves the broadest possible participation in the funding of care for the indigent.
- It encourages private insurance by rewarding those who provide for their own needs.
- It imposes a proportionately greater burden on those individuals and employers who choose to remain uninsured but who are capable of financing their own insurance.

In addition, while proposals to raise taxes will doubtless be opposed by many, it should be recognized that the cost of caring for the medically indigent is already borne broadly by society as a whole. Substituting a rational, stable financing mechanism for continued reliance on cost-shifting will benefit both the indigent and those who must currently pay for that care. It will also facilitate the development of systems for efficiently managing the delivery of the care needed by the medically indigent by enrolling them in well-designed public programs.

Opposition to higher taxes can also be reduced by charging those who benefit directly from coverage through public programs a reasonable premium tied to their ability to pay. Not all of the medically indigent are poor. Those individuals who are employed and can afford to contribute toward the cost of their coverage should be required to do so. A premium contribution by a family should be based on the actuarial value of the coverage it receives and its annual income.

In the case of long term care, similar principles should be applied. Specific recommendations are being develcped by an Ad Hoc Committee of the Board of the AHA. However, as with the uninsured, a long-range solution to the issue of financing long-term care will require a combination of public- and private-sector initiatives and will require both tax dollars and individual contributions to finance. Specifically, AHA supports federal tax incentives to promote individual financing of long-term care insurance, including incentives to promote savings and prepaid insurance. However, higher taxes will also be needed to finance long-term care for those whose needs exceed their financial resources. The financing of any program of long-term care "insurance" should, however, be kept separate from the financing of acute care benefits by Medicare.

CONCLUSION

The priority health policy issue facing the nation is how to reconcile the need and demand for access to the highest quality medical care with the nation's limited resources. For Medicare, this means putting the program on a financially sound footing and ensuring the effective and efficient use of the program's resources without compromising quality. For Medicaid, this means finding a way of adequately funding access to services for the nation's poor and uninsured who are unable to purchase private health insurance coverage.

Making sure that all Americans have access to care should be the fundamental goal of Medicaid. A minimum national eligibility floor for Medicaid would assure such access for the nation's neediest individuals. The President's interest and Congress' initiatives in eligibility expansion are important steps toward this goal. Other reforms are needed in the areas of enrollment incentives, financing, reimbursement, and coverage policies.

We believe that all employers should offer a minimal health care plan to all their workers and their families, just as they must provide a minimum wage and a safe environment. If coupled with the kinds of incentives and subsidies necessary to enable employers to comply, and if coupled with strong Medicaid reforms, a national mandate for employers would go a long way toward assuring that all Americans secure access to timely, cost-effective, quality care.

Public policy should encourage the private financing of long-term care services. When individual resources are inadequate, public financing must be used to assure access to long-term care.

Reductions in payment over the past five years threaten to compromise the ability of hospitals to maintain access to essential, high-quality medical care. A stable and reliable funding mechanism must be in place for Medicare and Medicaid to fulfill the promise of health care services to the poor, disabled, and elderly.

AHA recognizes the importance of reducing the federal deficit, but we believe hospitals have already contributed disproportionately to the effort. A significant effort is needed to make Medicare and Medicaid more fiscally reliable and to make the reforms that will ensure adequate payment and equitable treatment both for hospitals and program beneficiaries.

Even though controlling costs is of paramount importance, it cannot be achieved at the expense of quality care. AHA is working to help hospitals and their medical staffs to assure that Americans continue to receive the high-quality health care services they expect and deserve.

Although proposals to raise taxes will doubtless be opposed by many, it should be recognized that the cost of caring for the medically indigent is already borne broadly by society as a whole. Substituting a rational, stable financing mechanism for continued reliance on cost-shifting will benefit both the indigent and those who must currently pay for that care.

AHA has recommended several actions that can be taken to achieve these goals. We applaud your efforts thus far to address many of these problems and urge your continued focus. We stand ready to assist you in any possible way; it is only by working together that we will be able to patch the holes in the health care safety net.

Chairman **Rockefeller**. Thank you, Paul, very much. It's interesting as we have gone through the public sessions, this being our third and last one—we've done by far most of our work in private sessions with experts, but there hasn't been a public entry and that's just simply so we were freer to engage in dialog and counterattacks and things of that sort—that groups that come before us in public sessions are all committed to solving the problem.

Dr. Kolb, your views put the emphasis on the younger side of things and that's understandable.

Paul you spoke in terms of mandated health insurance or whatever is required to get people to be able to be insured because you've got a lot of uncompensated care across the land in hospitals. I was in one yesterday in Kentucky where that was very clearly a problem. Hospitals are closing in rural States and in urban areas and hospitals are losing a lot of money, a great deal of money.

Each person comes forward with an idea for the solution in which that individual entity is least affected. So, everybody has a solution, but it involves other people making sacrifices. And there have been a number who have come before us today from consumer groups who said we ought to be doing this, but then have been somewhat short in terms of how we pay for it.

And then the question of, is there a national will to do all of this and people say, yes, there is. And you know, I remember back 3 years ago when we were talking about catastrophic care, in fact, seniors were talking about catastrophic care. They weren't talking about long-term care. Then all of a sudden the bill comes out and people start talking about long-term care. So, everybody's got a problem and everybody's got a solution.

And I'm just asking you a generic question, what is it that the hospitals have to do, for example, if everybody has to give up something in all of this, if everybody has to share the pain? And I think that's going to be our assumption that shared pain is the only way that one comes out of this with access for all. What is it that hospitals can do in terms of their portion of increased shared pain?

Mr. **Rettig**. Mr. Chairman, one of the things I attempted to say, which I am sure you didn't miss, was that hospitals have already experienced a considerable amount of pain. Realistically we assume that they will continue, as long as it is understood that there are limits, if we want to preserve the hospital system we now have without having institutions go out of business, maybe not the ones you wish would go out of business.

In our testimony, we have indicated support for a variety of financing mechanisms, through premiums, taxes, and so forth, and mandating. We would also mention that hospitals are employers. To the extent that mandating, for example, affects them, hospitals are major employers, often among the most significant employers in their community. So, that pain, if you will, would fall on hospitals like other employers. Hospitals and their people are taxpayers, and we have indicated a willingness to back increased taxes of one kind or another, if that seems appropriate in financing increased coverage.

Finally in our longer testimony we indicate our support for effective research and the practice guidelines that come out of that. And so, we are willing to do our part to cooperate in helping assure that the services that are paid for are necessary services and not wastefully provided.

Chairman ROCKEFELLER. Let me just follow on that with one difficult question. Can you tell me whether there's evidence that some hospitals are refusing to take Medicaid patients on either an inpatient or an outpatient basis because of the relatively lesser reimbursement rates?

Mr. RETTIG. To my knowledge, hospitals do not do that. They have an obligation to serve all comers, including and especially Medicaid patients. You may recall that there was in pending legislation, on the House side, a proposal that would have required hospitals if they wished to participate in Medicare to also participate in Medicaid. We looked to see what hospitals that would affect, and it turns out to be a very, very few. And so, I do not have evidence. I do not deny that someone might be able to come up with a case, but as a general practice, hospitals don't turn away Medicaid patients.

Chairman ROCKEFELLER. Thank you, Paul, very much. Let me ask one more, Jim. Kathleen, you mentioned that there's a problem with the supply of practitioners and I think we would agree with that. And someone suggested there's a relationship between that and the question of medical liability. Would you agree with that?

Ms. HIGGINS. I think, in general, that certainly is true. Nurse-midwives, similarly to other primary care providers, family physicians, and obstetricians who provide those services, have seen their malpractice liability insurance rates grow to about 10 to 12 percent, we have averaged now, of our annual salaries, which is comparable with most obstetricians and family practice physicians.

Nurse-midwives have found some ways to get around that. Perhaps it's limited the number of individuals who have sought more entrepreneurial approaches to providing care. Nurse-midwives very often will align themselves with hospitals or health maintenance organizations or public health service organizations, so that their malpractice liability is assumed by either that facility or in some way—for instance, when I was directing a program in South Carolina because I was an employee of the State, the State underwrote the malpractice liability insurance. So, as a group nurse-midwives are probably doing somewhat better than other providers in obstetrical care. But we have had the same scrutiny as others.

Of course, our malpractice actuarial evidence is very different in that the numbers of suits brought against nurse-midwives is extremely small. That should not be surprising considering that the focus that we provide is on the normal childbearing family and you would not expect those people to have high levels of problems. But also the focus that we give to establishing very, very close rapport would also be recognized as a way to limit, perhaps, nuisance suits and those kinds of things.

We work primarily with poor people. We have always, traditionally worked with poor people. Nurse-midwives are on Indian reservations and in inner cities and rural areas. We haven't found that the perceived notion that people who are either uninsured or who have Medicaid insurance tend to sue more. But again, it may be that we have a skewed sample because of the kind of families for whom we provide care.

Chairman ROCKEFELLER. Thank you. Jim Balog.

Commissioner BALOG. It's a question I've wanted to ask somebody and it's a wonderful opportunity to do so. We've heard so many times in these hearings about the measures of the effectiveness of an American health care system and one of the statistics that's always used is our infant mortality rate. And I've always wondered how much of the infant mortality incidence, the rate, could be solved by medical concerns that we're dealing with here? How much of it, then, might be due to things like nutrition, substance abuse, housing, the diversity of our population, and how much of it is really medical that might be addressed through what we're talking about? So that we don't throw, you know, money at the wrong problem. Doctor? Doctors, both.

Dr. KOLB. Thank you for an excellent question. I think the issue of the infant mortality rate is a multifaceted issue. It's impossible to separate it out as to what portion is medical care because it may be access of a certain area of a community where people cannot get to that medical care or have barriers beyond just the availability of that care, socially or demographically.

I think nutrition definitely is a part of it, but do you call nutrition part of health care? Yes, it is. If you don't have good nutrition then your ability to be able to carry an infant to completion in the womb, to a healthy completion and have a healthy infant is significantly impaired. So, nutrition is part of health care under those parameters.

When you look, however, at the preventive capabilities within that system to say the health care system will effectively manage that, we can say that for a pregnant lady to come in and receive the health care from a health care system costs maybe $600 for total prenatal care. But if she were to deliver that infant prematurely and that baby spends 1 day in an intensive care unit it costs $1,000. So, I think there is a cost-effective measure that can be brought about and the preventive basis for the management of prenatal care.

All of these parameters impact on the infant mortality, but prematurity is by far the biggest parameter. And ways to deal with that are early recognition of difficulties, coming into a care system so that you are monitored and your problems are identified and taken care of, and healthy nutrition.

Commissioner BALOG. So, it's not medical care per se, but the early access to the system. Once in the system it goes all right. It's a question of getting there.

Dr. KOLB. That's correct. And identification of any difficulties that exist along the way which would be properly cared for that may stop a premature birth from occurring.

Commissioner BALOG. Mr. Chairman, may I follow up with one more question to Mr. Rettig? Another one that's been burning into my mind. You said in your remarks that while the percentage of GNP devoted to health care in our country has gone from about 6 percent to almost 12 percent in the matter of the last 15 years and you said in your remarks that hospitals are a constant 4.4 or 4.7

percent, I can't remember the number. So, if hospitals aren't doing it, who is the culprit? Why are costs going up so much?

Mr. RETTIG. The simplistic answer is the others.

Commissioner BALOG. The usual suspects, round them all up.

Mr. RETTIG. One must understand that a great deal of care has moved out of the hospital inpatient setting. There has been a lot of improvement in shortening stays while continuing to provide adequate quality of care. The figure I gave you actually does include hospital outpatient services as well. It's not limited to inpatient services. Nonetheless, a lot of care has moved out of the hospital setting elsewhere as we have become more and more able to do more complex procedures and render more care outside. That's one explanation.

There are numerous others that are much more complex, having to do with whether we have an oversupply of physicians, whether physicians generate their own demand, and a whole series of other things such as that.

Commissioner BALOG. We still keep searching for the answer, I think. I didn't get it from your answer. I'm still looking for it, but I imagine I'll just keep looking for it. I'm comparing the United States with other countries and I'm trying to figure out why this cost explosion is going on and the percentage of GNP is going up so much with others.

We don't have more hospital beds per capita, we don't have more physicians per capita, the average stay is going down not going up in the United States. And yet the one thing I've noticed, that the intensity of care—once you get into our system the intensity of care is very high, particularly in hospitals. You really pour on the medical technology. And I was wondering if you think the technology and the intensity of the applications of technology to health care is part of the problem?

Mr. RETTIG. I'm sure that technology is part of it and one will want to sort out, if one could, how much of that is truly increased quality that we, the society, want to pay for and how much of it is unnecessary or duplicative services. Part of it is new, that we can do new things. We can take care of people better.

So, when you're measuring, whether it's in the percentage of the GNP or whatever, the product in the sense of health care outcomes that you're measuring is really changing. So, in many respects, we're doing better than we did before. But I would agree that part of the reason we're able to do that is technology and I'm sure that we would not be alone in agreeing that in the use of technology there is probably some excess.

Chairman ROCKEFELLER. Yes, Doctor.

Dr. KOLB. Mr. Chairman, if I could just expand on that for a second. I think it's the responsibility of all of us within the health care system, in the public sector, in the private sector, to say that there's a lot of good health care information out there today that if we could get it to the public and we could have the public have access to our facilities and care in the preventive way, we would reduce some of the escalating costs.

The uninsured in this country, the unimmunized children in the country, who with this measles outbreak have died, those are costs that are costing us thousands and thousands of millions of dollars, the same as I mentioned with the prenatal situation. If we could have all those mothers informed of the value of preventive care and the effects of that and how much that would reduce the overall total health care dollar.

Chairman ROCKEFELLER. I'm going to have to cut it off here because we have one more panel with five people and only a half hour to go. So, I want to thank all of you for coming and for your testimony. We may very well pursue you with other questions. In the meantime, thanks so much.

Dr. KOLB. Thank you, Mr. Chairman.

Chairman ROCKEFELLER. Our final panel deals with the insurance industry and consumer representatives. Barney Tresnowski is president of the Blue Cross/Blue Shield Association; Carl Schramm, who in fact, has testified before us before, Health Insurance Association of America; William Irons, National Association of Life Underwriters; Sam Havens, Group Health Association of America; and Bob Hunter, National Insurance Consumer Organization.

Gentlemen, we welcome you and, Barney, we'll start with you.

STATEMENT OF BERNARD R. TRESNOWSKI, PRESIDENT, BLUE CROSS/BLUE SHIELD ASSOCIATION

Mr. TRESNOWSKI. Thank you very much, Mr. Chairman. You have my full statement. I'll just briefly summarize. We do welcome the opportunity to address the Commission on this important matter. You've had a long list of witnesses before you describing the trend over the past decade. We join them in their concern for the increase in the number of uninsured Americans.

Our testimony focuses on a two-part strategy to address the problem. They are Government incentives to encourage expanded private sector coverage and second, targeted Government efforts for people who are unlikely to purchase private coverage on their own.

Before I just quickly summarize that, I wanted the record to be clear on the substantial contribution of Blue Cross and Blue Shield plans to make insurance coverage available as widely as possible. The record should note that our plans continue to provide coverage to individuals and small groups, even though many carriers avoid these markets or in some cases have left them entirely because of the risk associated with insuring these subscribers. Nearly all Blue Cross and Blue Shield plans offer coverage to any small group at the same community rate, without adjustment for the medical condition of individuals within the group. Also a number of plans offer individual coverage to all applicants, regardless of health status, on a year-round basis.

In addition to these ongoing practices, Blue Cross/Blue Shield plans have developed a number of special programs to meet specific needs of the uninsured. These programs include those designed to cover important segments of the uninsured population, such as children, low-income individuals, employees of small businesses, and people who do not have access to employer-sponsored health insurance. I spell these special programs out in my full statement and will be glad to respond to questions about them.

However, as important as all of the activities that we pursue at Blue Cross and Blue Shield, we believe that Government has a key role to play in two areas. We recommend, as a first step, that the Federal Government give the private sector more flexibility to offer low-cost benefit packages. The Federal Employee Retirement Income Security Act, ERISA, allows self-funded employers, usually large employers, to tailor the benefits they offer by preempting the State-mandated benefit laws. However, insured products, the type that smaller groups generally purchase, remain subject to those mandates and they're very expensive. We recommend that the ERISA exemption be extended to all health benefit plans, both insured and self-funded, to allow insurers to develop the type of lower cost benefit packages that would be more attractive and affordable to small employers.

Second, we think the Federal Government should encourage greater employment-based coverage by equalizing the tax treatment of self-employed individuals who provide health benefits. You know, currently the self-employed can deduct only 25 percent of the cost of providing health benefits, and this provision will expire at the end of this year. We recommend not only extending the 25-percent deduction, as provided in the House passed reconciliation bill, but expanding the deduction to the 100-percent level available to others.

These two steps would go a long way to encourage private sector insurance coverage of uninsured small employers. However, there will continue to be gaps for individuals who cannot take advantage of private insurance and, for those groups, we recommend that Government do a couple of things.

First, do some things with the Medicaid Program. There should be a mandatory minimum income eligibility level for States, eligibility should not solely be based on welfare categories, and there should be a sliding scale subsidy of health benefit expenses for the low-income working uninsured with income above Medicaid eligibility levels, but below 150 percent of the Federal poverty level.

We also believe the Government needs to address the problem of individuals with medical conditions so severe that they are considered uninsurable. Voluntary State risk pools, where needed, are one means of making coverage available for these individuals. State general revenues could be used to help subsidize the risk pool losses, or, in those States that have adopted assessments on insurers to finance the pool losses, we advocate that there be Federal legislation that will allow States to extend responsibility for risk pool subsidies to self-funded as well as insured plans.

Mr. Chairman, in our statement we've offered you some ideas on a couple of proposals that are before the Congress at the present time. In addition to that, I would simply conclude my remarks by saying that we at Blue Cross and Blue Shield think this is a very serious subject. We have it under active consideration at the moment and we are reviewing a series of considerations. One is, should the insurance market be placed on a more level playing field in terms of risk selection? Should there be standards of business behavior that apply to all insurance carriers?

Second, mandating health coverage without a corresponding cost-containment strategy is folly. Just to spend $23 billion in new money into this business, and it's an overheated engine, without a corresponding cost-containment strategy doesn't make any sense at all.

And third, there has to be a better imaginative way of financing a program of this kind. You just can't put the burden on the employer. You've got to think about a more pluralistic approach to financing.

And those are the considerations that we are looking at at the present time. I'll be glad to answer any questions and we do thank you.

[The prepared statement of Mr. Tresnowski follows:]

TESTIMONY

OF THE

BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

HEALTH COVERAGE FOR THE UNINSURED

BEFORE THE

PEPPER COMMISSION

BY

BERNARD R. TRESNOWSKI

OCTOBER 24, 1989

Mr. Chairman, and Members of the Commission, I am Barney Tresnowski of the Blue Cross and Blue Shield Association. The Association is the coordinating organization for the 73 Blue Cross and Blue Shield Plans throughout the nation. Collectively, the Plans provide health benefits protection for more than 80 million Americans.

Since its inception in the 1930's, the Blue Cross and Blue Shield organization has been committed to developing and improving the nation's pluralistic health financing and delivery system in partnership with consumers, employers, unions, government, and health care providers. That commitment continues today as we address what is perhaps the most complex current health financing issue -- the needs of the remaining uninsured.

We welcome the opportunity to address the Commission on this important matter. We are concerned, as you are, about the trend of the past decade--a rise in the uninsured population from 25 million to well over 30 million people.

Today my testimony will focus on responses to three key questions:

- First, how well has the current mix of public and private programs performed in extending health benefits?
- Second, what is the best way to address the health care needs of the uninsured?
- Third, what are the views of the Blue Cross and Blue Shield Association on various proposals to improve access to care for the uninsured?

HOW WELL HAS THE CURRENT SYSTEM PERFORMED?

The nation's current system of health care coverage provides protection for approximately 83 percent of Americans under age 65 through a combination of private and public sector programs. Estimates by the Congressional Research Service of health insurance coverage illustrate the wide extent of coverage. Of the population under age 65:

- 65 percent are covered through employment-based private health insurance;
- 11 percent are covered through other sources, such as individual insurance; and

- 9 percent are covered by Medicaid or Medicare.
- 4 percent are covered by CHAMPUS.

These numbers demonstrate the success of our current system, but they also reveal the lack of health benefits protection for over 30 million individuals.

HOW CAN WE BETTER MEET THE NEEDS OF THE UNINSURED?

We recommend a two-part strategy to address the problem of the remaining uninsured. This approach combines government incentives to encourage expanded private sector coverage and targeted government efforts for people who are unlikely to purchase private coverage on their own.

First, let me describe what the Blue Cross and Blue Shield system already is doing to make insurance coverage as widely available as possible. Blue Cross and Blue Shield Plans continue to provide coverage to individuals and small groups, even though many carriers either avoid these markets entirely or have left these markets because of the risk associated with insuring these subscribers.

A number of Blue Cross and Blue Shield Plans offer individual coverage on a year-round basis regardless of health status--to people no other insurer would accept.

Other Plans offer coverage to any applicant at specified times during the year.

Nearly all Plans also offer coverage to any small group, at the same community rate, without adjustment for the medical condition of individuals within the group. Most Plans have continued this practice even as they see their better risks leave to purchase coverage from insurers who can offer a price that reflects the applicant's lower risk.

In addition to these ongoing practices, Blue Cross and Blue Shield Plans have developed a number of special programs to meet specific needs of the uninsured. These programs include those designed to cover important segments of the uninsured population such as children, low-income individuals, employees of small businesses, and people who do not have access to employer-sponsored health insurance.

In recognition of the high number of uninsured children, many Blue Cross and Blue Shield Plans have developed innovative products especially designed for children.

> Caring Program: The Caring Programs for Children are charitable, nonprofit insurance programs that provide primary health care benefits free of charge to children of low-income families who are not eligible for Medicaid. The original program was developed in 1985 by Blue Cross of Western Pennsylvania and Pennsylvania Blue Shield. Since its inception, the Western Pennsylvania Caring Program for Children has provided over 10,000 children with primary preventive and emergency health care service coverage at no cost to their families.

As of September 1989, nine other Blue Cross and Blue Shield Plans had established Caring Programs in their states: Alabama, Iowa, Maryland, Missouri, North Dakota, North Carolina, Ohio, Syracuse NY and Kansas. Four additional Blue Cross and Blue Shield Plans are scheduled to have Caring Programs operational by late 1989.

Funds for the program are raised from the community. In addition, several Blue Cross and Blue Shield Plans match contributions dollar for dollar and many Plans also subsidize the administrative costs of the program so that every dollar contributed goes directly to providing health care services for enrolled children.

Preferred Youth Care: In another effort to provide affordable insurance coverage for children, Blue Shield of California offers a product that significantly reduces the cost of health insurance for children by establishing special rates for children. The rates are based on two age categories--1 to 4 years and 5 to 18 years--and vary depending upon the deductible chosen. For example, traditionally rated coverage for a child would cost $109 per quarter. Under this program, coverage for a child age 1 to 4 would be $80 per quarter while coverage for a child age 5 to 18 would be $63 per quarter.

Initiatives also are underway to develop products for the nearly two-thirds of the uninsured population who have incomes below 200 percent of the federal poverty level.

ValueMed: Blue Cross and Blue Shield of the Rochester area recently developed a low-cost health insurance product that provides coverage for low-income residents. The new coverage, called "ValueMed", is designed for those under age 65 who have no health insurance--primarily young working adults in low-paying jobs and their families.

To keep premiums low, the Plan is subsidizing administrative and other costs and has contracted with nearly 500 physicians and with hospitals in 6 counties to provide discounted services. Monthly premiums are $39 for single coverage, $70 for family coverage and $10 per child for dependent-only coverage. To be eligible for coverage, annual family income must be below 175 percent of the federal poverty level.

> BasiCare: Another example of Blue Cross and Blue Shield Plan efforts to provide insurance coverage to low income populations is a basic benefit program called "BasiCare" which is offered by Blue Cross and Blue Shield of Iowa. This product, which costs only about $50 a month for an individual, covers inpatient hospitalization, outpatient surgery and emergency and accident care. BasiCare is available to individuals through their employers or by direct payments.

Blue Cross and Blue Shield Plans also have developed products to address the needs of those who are without access to employer-based health care coverage.

> Impact: Blue Cross and Blue Shield of Tennessee offers "IMPACT", a comprehensive, non-group product line which is available to self-employed individuals, employers with four or fewer employees, students and other individuals without access to health care benefits under a group plan.
>
> The product incorporates cost-saving features commonly found in large group products, such as pre-admission certification and testing, concurrent care review, and voluntary second surgical opinions.
>
> With a 10-percent discount for non-smokers, IMPACT offers premiums as low as $28.13 a month for individual subscribers under age 29.

These programs have helped improve access to needed health services. However, we believe that government action to increase flexibility to provide more affordable benefit plans, and to increase incentives for employers to provide coverage would enable us to do even more to expand private sector health care coverage. We recommend the following:

1) Amend ERISA To Allow More Affordable Benefit Plans

As a first step, the federal government should give the private sector more flexibility to offer lower cost benefit packages. While smaller employers who may want to offer benefits have the greatest need for more affordable benefit packages, insurers have the least ability to meet that need because of state mandated benefit laws. These mandates vary by state but can include benefits that add considerably to the cost of coverage--as much as 20 percent in some states.

The federal Employee Retirement Income Security Act (ERISA) allows self-funded employers, usually large employers, to tailor the benefits they offer by preempting these state mandated benefit laws. However, insured products--the type the smaller groups generally purchase--remain subject to those mandates.

The Blue Cross and Blue Shield Association recommends that the ERISA exemption be extended to all health benefit plans--both insured and self-funded--to allow insurers to develop the type of lower cost benefit package that would be more attractive and affordable to small employers.

2) Equalize Tax Incentives for Employer-Provided Coverage

Second, the federal government should encourage greater employment-based coverage by equalizing the tax treatment of self-employed individuals who provide health benefits.

Currently, the self-employed can deduct only 25 percent of the cost of providing health benefits, and this provision will expire at the end of this year. In contrast, incorporated businesses can deduct 100 percent of their health benefit expenses. We recommend not only extending the 25 percent deduction, as provided in the House-passed reconciliation bill, but expanding the deduction to the 100 percent level.

These two steps--extending the ERISA exemption to all health benefit plans and equalizing tax incentives for employer-provided coverage--clearly would help encourage private sector insurance coverage of uninsured small employers. However, coverage gaps will remain because not all individuals can take advantage of private insurance. For these groups, which include low-income and high-risk individuals, we recommend the following government initiatives:

3) Expand Medicaid for the Low-Income

We recommend a three-part Medicaid strategy to address the coverage needs of low-income workers and noon-workers:

- Adopt Mandatory Income Eligibility Levels. First, the federal government should set a mandatory minimum income eligibility level for states. If necessary because of the additional cost to states (and the federal government), the minimum eligibility level could be phased in over time. Currently, the Medicaid program covers only about 40 percent of individuals and families with incomes below the federal poverty level.
- Break the Welfare Link. Second, the Medicaid program should be modified to eliminate eligibility based on welfare categories of the aged, blind, disabled and members of families with dependent children. Anyone, including working individuals and their families, should be eligible for Medicaid if their income is below the income eligibility threshold.
- Subsidize Benefits for the Low Income Working Uninsured. Finally, the federal government should consider a sliding scale subsidy of health benefits expenses for the low income working uninsured with income above Medicaid eligibility levels but below 150 percent of the federal poverty level. This subsidy could be implemented by providing a limited Medicaid subsidy of the expenses of certain employer-based health benefits or by allowing a buy-in to a limited Medicaid package.

These changes would eliminate wide differences in Medicaid eligibility and substantially improve health insurance protection among low-income working individuals.

4) Voluntary State Risk Pools

We also believe that the problem of individuals with medical conditions so severe that they are considered uninsurable need to be addressed through government sponsored programs. Voluntary state risk pools are one means of making coverage available. These are state sponsored pools that offer coverage to those who, because they have a severe medical problem, cannot obtain private insurance coverage.

However, the need for such pools varies on a state-by-state basis. Many Blue Cross and Blue Shield Plans--21 Plans in 12 states--do accept all applicants, either during an open enrollment period or on a continuing bases, regardless of the applicant's medical status. In these states, there is no need for a state high risk pool.

We believe that the financing of pool losses should be as broad-based, and therefore as equitable as possible. Most states with risk pools have chosen to finance pool losses by assessing insurers for the shortfall. As a result, the burden for subsidizing current pools falls largely on employers who purchase insurance coverage--mostly small and medium-sized employers. This approach does not include employers who contribute the most to the uninsured problem--those who do not offer health insurance benefits.

Nor does it include most large employers, because these employers generally self-fund their health benefits, and as a result are exempt from participating in risk pool financing under ERISA.

State general revenues represent the best financing source. However, recognizing that most states have adopted insurer assessments to finance pool losses, we would support an assessment which requires all employers to share in the financing of pool losses, not just those who offer health benefits to their employees. In the absence of such actions, we would support federal legislation to allow states to extend responsibility for risk pool subsidies to self-funded as well as insured plans.

WHAT ARE BCBSA'S VIEWS ON PROPOSALS TO IMPROVE ACCESS?

Finally, I would like to present the Blue Cross and Blue Shield Association's views on two proposals for increasing access to care: requiring employers to provide coverage to their employees, and giving employers a choice between providing coverage directly or paying a "tax" based on a percentage of payroll and sending employees to a state-run pool for coverage.

Both of these proposals recognize the key element of the uninsured problem--the inability of low wage workers to command employer-provided health benefits. The requirements of minimum benefit standards and employer contributions clearly would help assure the availability of more affordable coverage for such workers.

However, we are concerned that adding to employers' costs through a mandate approach--whether direct or indirect--could adversely affect some workers and their families. Some employers may compensate for the additional cost by reducing cash wages, changing employment practices or even laying off some workers.

We also have a very fundamental concern with an approach that would give employers a choice between providing coverage directly or paying some sort of tax penalty. This is the approach proposed by the National Leadership Commission on Health Care.

Our concern with this approach is that it would create a significant incentive for employers to drop employment-based health insurance in favor of paying the payroll tax "penalty". This incentive arises because the penalty initially may be less expensive for employers than providing coverage directly.

Additionally, we believe that this approach raises some very troublesome public policy issues. This approach could, in time, restructure the entire health care system--from a pluralistic system to a system of central control and heavy regulation. Instead of "building on the American tradition of providing private health insurance through the workplace", as the Leadership Commission claims, it is entirely possible that the state run pools proposed by the Commission could evolve into the primary mechanism for health care financing.

A centralized system would diminish responsiveness to individual health care needs of employees and employers. No longer could employers and employees negotiate to determine the most appropriate benefit package. Nor would the accountability and responsiveness of the employer-managed system be retained, especially with regard to individual employee problems. Instead, all employees would be forced to work through an elaborate state bureaucracy.

Conclusion

In conclusion, the Blue Cross and Blue Shield Association shares the Commission's desire to improve access to health care. We will continue to examine various approaches that expand coverage of the uninsured, while preserving the positive aspects our current system.

We look forward to working with you on this important issue. Thank you for the opportunity to express our views today.
0110c

Chairman **Rockefeller**. Just a quick one. Your last point, were you saying that we should not address how to do the comprehensive aspect of this until cost containment has been addressed, or that these two can go on concurrently?

Mr. **Tresnowski**. No; I think they can go on concurrently. I'm simply making the point that spending a lot more money, pouring a lot more money into an overheated system, is just going to make it worse than it is today. You really need a cost-containment strategy while you're talking about a mandate.

Chairman **Rockefeller**. Carl Schramm.

STATEMENT OF DR. CARL J. SCHRAMM, PRESIDENT, HEALTH INSURANCE ASSOCIATION OF AMERICA [HIAA]

Dr. **Schramm**. Thank you, Mr. Chairman. Our member companies insure 90 million people. Coupled with Barney's 76 plans, 180 million Americans are covered by private health insurance. At the outset of your second public hearing, Mr. Chairman, you made a preamble remark that basically challenged witnesses to come up with solutions, not just describe problems to you, and it is in that spirit that we come before you today. We have been working at HIAA over 2 years on the question of access.

I'd like to put before the Commission today four specific points of action that would go a long distance to resolving the problem of access in this country. From the outset I think our premise has to be a return to the concept of 1965, that to cover all Americans requires a public and a private partnership.

The first part of our proposal would match, I think, virtually everything that Barney has just laid out in terms of the reform of title 19, the Medicaid Program. It was appreciated in 1965 and has to continue as an appreciation, I believe, among all policymakers, that the private sector cannot reach a market that does not have the means to participate in a market; namely, poor people must be the principle responsibility of the public sector.

As we revisit our commitment to Medicaid, we would propose, I think in unison with Blue Cross, the elimination of categorical restrictions on eligibility. We strongly suggest the decoupling of the welfare system from the Medicaid system. We would eliminate eligibility restrictions for individuals and families who may be employed, but still remain below the eligibility income standards.

At the association we have developed, in the last year, a proposal regarding Medicaid that takes into account the dynamic aspects of poverty such that people who essentially were moving into poverty would be able to buy into the program with a public subsidy. As people who were above the poverty line encountered instability in their employment relationships they would spend down quickly into Medicaid coverage. And as unemployed people on Medicaid moved into the labor market there would be public subsidy for the employee's share of any premiums as they participated in an employer-sponsored program.

Now to be sure, this will cost public funds, someplace in the area of $6 to $10 billion, but we believe this is required essentially to move, as you've heard from other witnesses, the Medicaid Program back up to some respectable level of coverage of people under the Federal poverty standard.

The second point we would make concurs with the testimony of Blue Cross regarding ERISA preemption. In order to make affordable insurance available we must see Federal preemption of State-mandated benefits extended to insured employer plans. This is required, essentially, to evade the disparities in the unlevel playing field and the high costs of the mandated benefits imposed at the State level.

The third point we would offer is the development of pools for people who are medically uninsurable. And I think our position would, again, mesh with the Blue Cross plan. For several years the association has worked vigorously in the States. We can proudly point to 20 States that have enacted pools for uninsurable individuals. The losses of these pools are generally financed either by State general revenues or by the private insurance industry, essentially assessing the insurance companies writing plans in those States. These pools are financed exclusively by covered employments, that is, insured employer plans, and are not assessing the self-insured employers.

The second point of this would require the establishment of a reinsurance mechanism operated and financed by the private sector. We are busy at work on that proposal. We see it as our obligation principally to establish a reinsurance mechanism for small employer group plans. And we hope to return to you shortly with some specifics in this area.

Finally, we would concur with Blue Cross on the question of self-employed individuals, giving them a 100-percent tax deduction for health insurance.

I conclude just by pointing out, again, the whole premise here is that this is a partnership that has to be reforged between the public sector and the private sector. With regard to your comments at the end of the formal testimony of the last panel, many have come before you and essentially said it's your responsibility to fund this. I think the premise that we have been operating on, inside the private insurance industry, is that we, in fact, have to be part of the solution and the solution will be painful for us.

A week ago Sunday the HIAA board of directors met in Cincinnati and established a board committee to lay out the framework for our reinsurance proposal. Going into that, the premise is fully understood that we will have to take a good look at our underwriting practices, we will have to take a good look at how we fund, in the private sector, a plan to which small employers could apply through insurers to find affordable insurance. This will be painful. It will be built somewhat on the architecture of the State plans that we have helped create, and have proposed to the Congress. However, our reinsurance proposal for small employers would be essentially financed by the private sector, indeed financed by the private sector exclusively.

This is a blueprint. It's hard work. It's going to be a partnership and I think you'll shortly hear of other hard work that's being done in Blue Cross plans and in the private sector to deal with the joint problem of cost containment. If we do not settle the cost-containment problem at the same time we work on the access problem, we will not solve the access problem. It's as simple as that. Cost inflation is the engine that has driven this to center stage and until we deal with that problem, we can't finally settle the access problem. Thank you.

[The prepared statement of Dr. Schramm follows:]

Statement
# of the
Health Insurance Association of America

on

ACCESS TO HEALTH CARE FOR ALL AMERICANS

Presented by
Carl J. Schramm
President

Before the
Bipartisan Commission
on Comprehensive Health Care

October 24, 1989

I am Carl J. Schramm, President of the Health Insurance Association of America. HIAA is a trade association representing some 350 insurance companies who write approximately 40 percent of the health insurance in this country. The combined efforts of HIAA's members, the Blue Cross-Blue Shield plans and HMOs have succeeded in protecting 180 million Americans. However, we recognize that this is not enough.

Our member companies are greatly concerned about those 35 to 37 million Americans who do not enjoy the protection of health insurance. Over the last two years, our membership has worked hard to develop creative solutions for extending health care benefits to uninsured groups and individuals. Our companies are committed to working with government to implement effective approaches for providing coverage to this population.

The task of ensuring that all Americans enjoy the protection of insurance is complex. This complexity is largely a function of the heterogeneity of the uninsured population; this heterogeneity requires a combination of private and public solutions.

Roughly three in ten of the uninsured are poor (with family income below 100% of the federal poverty level); three in ten are low income (between 100% and 200% of the poverty level); and four in ten are non-poor (above 200% of the poverty level).

Eleven percent of the uninsured are the self-employed and their families; 13 percent are half-time employees and their families; and 51 percent are full-time employees and their families.

Finally, uninsured workers are disproportionately employed in certain industries (retail trade and services) and by smaller firms.

All of the above factors make formulating any strategy for a public/private solution difficult. As such we see the need to address the special needs of the various subpopulations within the 37 million uninsured with a simultaneous multi-pronged approach. We propose a specific four-point plan which, taken as a whole, provides a comprehensive blueprint to cover the uninsured. Key portions of our proposal are geared specifically, however, towards making health insurance plans more affordable and accessable to small businesses.

The first part of our recommendations involves expansion of the Medicaid program.

A. Expansion of Basic Medicaid Coverage

Ultimately we would like to see all Americans with incomes below the federal poverty level (and with limited assets) eligible for Medicaid, regardless of family structure, age or disability status. Accomplishing this would require severing the linkage between Medicaid eligibility and cash assistance.

If available funds do not permit full coverage up to the poverty level, HIAA believes priority should be given first to younger children, next to older children and finally to other populations. Priority should also be placed on primary care and preventive services. Unlike some other populations, many poor children do not have access to federal health care financing programs other than Medicaid (i.e., Medicare). This priority also reflects the critical need that children and pregnant women have for preventive services.

B. Limited Medicaid Buy-In

Individuals and families with incomes above poverty but below 150 percent of the federal poverty level should be eligible to purchase first-dollar coverage of a limited package of primary, preventive and related ambulatory care through their state's Medicaid program.

The benefit package would include basic ambulatory services such as well-child care and immunizations, prenatal care, basic diagnostic services including laboratory tests and x-rays, primary treatment services, monitoring of chronic illness, and outpatient prescription drugs according to the state's Medicaid formulary. Inpatient services would not be covered, nor would outpatient drug or alcohol services, mental health services, cosmetic surgery, treatment of infertility, major outpatient surgical procedures, or home health care (other than maternity-related).

Such a limited benefit package meets the near-poor's need for access to basic primary care (so that illness does not become more severe and expensive through lack of treatment), while not significantly lessening employers' incentives to offer basic insurance protection. As employer plans often incorporate a deductible in an amount which would be a relatively significant barrier for the near-poor, there should be only minimal overlap between buy-in benefits and employer-provided coverage.

The limited benefit package keeps costs of the buy-in coverage per se to a minimum, thus permitting very low premiums, constraining government costs, broadening participation, and reducing the chance of adverse selection. (Assuming realistic participation rates by eligible persons, our preliminary estimate of total federal and state costs of the buy-in is in the $1 billion range.)

A sliding scale of premiums should be developed so that, at the upper end of the income range, the charge would approximate the actuarial value of the coverage, not to exceed 15 percent of the family's income in excess of the federal poverty level. We are developing a specific benefit package proposal that would cost about $50-$60 per month for a family of three. If five income brackets were used, for example, the suggested monthly premium charges would be as follows:

Family Income as a Percent of Poverty	Monthly Premium Charge
100 - 109 %	$ 6
110 - 119 %	18
120 - 129 %	30
130 - 139 %	42
140 - 149 %	54
150 % + over	not eligible

Because some public subsidy is involved, eligibility would be restricted to persons with limited incomes who do not have substantial assets. However, the current Medicaid asset test should be liberalized to assure that working families would not have to impoverish themselves in order to obtain access to basic primary care. Homes, and cars of normal value, should be protected. The limit on liquid assets should be liberalized somewhat, perhaps to the $12,000 level Congress recently found acceptable for spouses of nursing home residents. A selfdeclaration process could be used to minimize administrative burden.

C. Spend-down

Persons not otherwise eligible for Medicaid due to higher income should become eligible for full Medicaid coverage once out-of-pocket medical expenses reduce their remaining income to the federal poverty level.

Some coverage of last resort is needed to cover inpatient care and other large out-of-pocket expenses for the near-poor who cannot afford to purchase private insurance on their own and whose employers do not offer it or offer only very limited coverage. Ensuring such coverage of last resort should be accomplished by requiring that all states establish "spend-down" coverage at the federal poverty level. This would establish a uniform national eligibility policy for the more limited "medically needy" option, now used by 36 states. The asset test should be adjusted to assure that the home, and cars of normal value, would be protected; but, to avoid incentives to drop private insurance, the limit on liquid assets would be left to state discretion, as it is now.

The major current problem with spend-down -- it does not finance early access to primary and preventive care -- is remedied by making "buy-in" available for primary, preventive and related ambulatory care.

D. "Buy-Out"

HIAA also recommends that Medicaid eligibles who are working be encouraged to make use of employment-based health insurance, where it is available. To accomplish this goal, state Medicaid programs should be given the option of paying (and receiving federal matching funds for) the employee's share (if any) of the private insurance premium, as well as other costs. Medicaid would continue to be available to cover deductibles and other benefits not covered under the employer plan; and Medicaid's contribution, for the employee's premium plus Medicaid's "wrap-around" coverage, would not be permitted to exceed the average cost of traditional Medicaid coverage.

Under our proposal, states would have the option of "buying out" two groups. First, more working people will qualify for Medicaid as the income level is raised to the poverty level for more persons and categorical restrictions are removed. Allowing states to pay the employee's premium share for any working Medicaid eligible seems a sensible way to reduce government outlays and encourage reliance on mainstream private, rather than government, benefits.

Second, current public policy supports the concept of encouraging low-income persons to work by easing the transition from public support to self support. One component of this policy is to integrate low-income persons returning to work into mainstream, work-provided benefits while continuing to provide government support for other necessary services during a transition period. The most recent example of this is the Welfare Reform Act, which extends Medicaid eligibility for 12 months after a family loses cash welfare payments because of a return to work and permits states to pay the employee's share of employer-provided health insurance.

As such, states should also have the option of paying the employee's share of available group coverage during the first year after the worker loses regular eligibility for Medicaid. For the first six months after loss of regular eligibility, there would be no income limit on eligibility for this premium subsidy. For the second six months, Medicaid payment of the employee's share could continue only for workers whose family income remained less than 150 percent of the federal poverty level. As under welfare reform, states would be allowed to charge a nominal premium during the second six months, based on the family's income as a percent of the federal poverty level.

For both the "buy out" of Medicaid eligibles and the "buy out" of individuals transitioning off Medicaid, participating employers should be required to make the same premium contribution on behalf of Medicaid-eligible employees as they do for other employees.

We believe that the federal government can rely on states to take advantage of the "buy out" option if and only if it is financially advantageous to the state and the federal government (considering the benefits available under the employer plan and the charge to the employer/state to obtain them.) Since the employee's share of employer-provided coverage will usually be significantly smaller than the amount Medicaid would expect to pay to provide benefits directly, states would probably make extensive use of this option. While states should be permitted to make this decision on an employer plan-by-employer-plan basis, they must not be permitted to discriminate among individual employees.

2) As the second piece of our four point plan, insurers should be allowed to offer more affordable coverage, including prototype plans. ERISA preemption of state mandated benefits should be extended to insured employee plans as well as to self-insured plans so that insurers can design less expensive benefit packages for small businesses.

Once legislators start down the road of mandating benefits, it seems impossible for them to stop adding new ones. Our experience in the states has proved that, where state legislatures have enacted over 600 mandatory benefit laws, starting with mental health benefits and alcohol and drug abuse treatment and ending with everything from acupuncture and pastoral counseling to in vitro fertilization and wigs. Ironically, while these mandates do not apply to the vast majority of large employer and union plans (which are self insured) they do apply to most small employers who simply cannot afford them. A study by a respected health economist at the University of Illinois estimates that as many as 16 percent of uninsured small employers fail to offer coverage because of state service and provider mandates.

HIAA will also support statutory changes to enable insurers to make lower cost prototype plans available. All prototypes would be actuarially equivalent in value and include basic inpatient and outpatient physician, hospital and diagnostic services. Additional services, such as dental and mental health, would be offered in some of the prototypes in exchange for higher copayments. In all prototypes, managed care features would be permitted.

3) Coverage must be made available to all Americans. This is true, even for those whom insurers might normally decline due to existing high cost medical or occupational conditions. There are two components to consider here: uninsurable employer groups and uninsurable individuals.

To ensure access to affordable group coverage for all employees, a nonprofit organization should be established to reinsure high cost employer groups. Employers would access the reinsurance organization indirectly via insurers, or directly if unable to purchase coverage through an insurer. Losses incurred by the reinsurance organization could be financed entirely by the private sector if shared equitably among competitors in the small group market and all larger health plans whether insured or self-insured.

HIAA also seeks Federal legislation encouraging all states to enact a qualified state pool for medically uninsurable individuals. Such pools have already been enacted in 17 states. Each pool should be a nonprofit corporation with coverage available only to uninsurable individuals who are not eligible for coverage by employer plans, Medicare or Medicaid. Pool losses should be financed by state general revenues or any other broad based funding mechanism that does not assign losses disproportionately to any individual or corporate entity. In the absence of action by a state, the Secretary of the Department of Health and Human Services (HHS) should establish a qualified pool in that state, in which case losses, if any, would be paid from federal health funds the Secretary would otherwise spend in the state.

4) Small businesses should be given a greater incentive to provide coverage for their employees. Self-employed individuals should get a 100 percent deduction for their health insurance protection, as long as they provide equal coverage to their employees. The 25 percent deduction which expires this year under current law, should be extended and increased, as provided in H.R. 2121, introduced by Congressmen Dorgan and Brown and co-sponsored by members on both sides of the aisle.

Our proposals are designed to meet the needs of a heterogeneous uninsured population. We believe that they should be given an opportunity to work before government turns to unnecessarily onerous mandates. Our four-point plan provides a blueprint for a truly comprehensive approach to solving the problem of the uninsured. The plan stresses the sharing of responsibility between government and the private sector. In our proposal we are calling on government to assist those who cannot be expected to pay for coverage on their own. We in turn will ensure that for everyone who can afford private coverage it will be available.

Thank you.

Chairman **Rockefeller**. Thank you, Carl, very much. Mr. Irons.

STATEMENT OF WILLIAM V. IRONS, NATIONAL ASSOCIATION OF LIFE UNDERWRITERS [NALU]

Mr. **Irons**. Thank you, Mr. Chairman and members of the Commission. My name is William Irons and I'm pleased to have the opportunity to comment on behalf of the National Association of Life Underwriters and the 1,000 State and local associations and their 140,000 life and health insurance agents I'm representing here today.

Providing health care coverage for all Americans is among the most vexing and challenging problems we face as a Nation. I've seen the problem from both the private and public sector view. I've been a life and health insurance agent for 20 years, but for the last 7 I've been a Democratic member of the Rhode Island State Senate. As a legislator I face some of the same health care issues that you are now examining. I know first hand about the difficult choices that lie ahead for this Commission.

As insurance agents, my colleagues and I also know about the difficult problems in obtaining health care coverage and paying the premiums which businesses and individuals face in the marketplace. We are actively involved in the sale of individual and group insurance, as well as disability and long-term care products. My colleagues and I are more often than not the bearers of disturbing news about premium increases and reduced coverages. At the same time, we are in the forefront of the effort to get increased numbers of individuals and businesses covered by health insurance. We're trying to do our part to increase the number of individuals who are covered by health insurance, particularly working people.

NALU believes that a multipartite approach would go far and bring more individuals into the health care system, which should ultimately result in the universality which we espouse. Those who can be covered by private insurance should be encouraged, whenever possible, and through appropriate tax incentives, to obtain such coverage. However, if an individual was unable to maintain private insurance due to preexisting medical conditions, or other underwriting considerations, or because appropriate individual coverage is unavailable, unaffordable by a person who works for an employer that does not offer group health insurance, a second alternative should be utilized; namely, through risk pools.

Coverage should be available through State or regional risk pools which fully spread the risks associated with insuring those persons who cannot otherwise obtain coverage. This risk spreading amongst the general population should include reasonable premium payments by participants. If a person cannot afford or otherwise qualify for coverage through such State or regional risk pools, broader governmental intervention is required. As a last resort, coverage should be available through expanded Medicare or Medicaid Programs. NALU believes that society as a whole is ultimately responsible for making sure that its poor have access to quality health care.

Mr. Chairman, NALU opposes the concept of employer-mandated coverage and would urge the Commission to reject such a concept as envisioned in Senate bill 768. While its goals are admirable, the public and private costs seem to discourage its adoption. At one time the Congressional Budget Office estimated this approach to add $27 billion to the cost of employment-based plans. Some private think tanks believe the cost to be closer to $100 billion.

From my experience, my personal experience, the cost of employee health insurance is a real barrier to many businesses. Insurance agents try all the time to encourage businesses to buy such coverage for their employees. The response quite often is: "I'd love to, but we just can't pay for it now. If the Government requires it we would go out of business." Believe me, Mr. Chairman, that is a typical refrain and legitimately based.

Mandated health insurance would be a major blow to many small American businesses. It would result in no insurance and no job.

Joint efforts by private industry, Federal, State, and local governments are required to solve this national crisis. No one entity can do it by itself. Though it is easy for industry and Government to incriminate one another for their lack of response, it is time—no, it is past time—to begin working together in an effort to find the answer to the problem. Government and business sectors must join to assist those who cannot fully pay their health insurance costs out of their own resources.

We must continue to examine innovative strategies, as our industry has already begun to do, such as the various uses of life insurance to fill health insurance needs. Ideas which include the acceleration of payment of life insurance benefits for victims of AIDS or other terminal illnesses, using life insurance to pay for long-term care benefits, and others yet to be discovered, which the industry through the assistance of Government by a favorable tax treatment can employ to facilitate greater access to health care.

These strategies, though not all encompassing in nature, offer what we believe to be an excellent beginning. The private sector does not have all the answers. However, we are, and must continue to be, a part of the mechanism whose purpose is to solve the Nation's uninsured problem.

In conclusion, NALU urges the Pepper Commission to develop a system, which we would hope would be along the guidelines suggested in our remarks, which utilizes the present private health insurance system without resorting to a new and cost-prohibitive national health insurance program, or an employer-mandated program. Thank you, Mr. Chairman.

[The prepared statement of Mr. Irons follows:]

STATEMENT

by

William V. Irons, CLU

on behalf

of the

NATIONAL ASSOCIATION OF LIFE UNDERWRITERS

to the

UNITED STATES

BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

("PEPPER COMMISSION")

Honorable John D. "Jay" Rockefeller IV, Chairman

October 24, 1989

The National Association of Life Underwriters (NALU) is pleased to have the opportunity to testify before the Bipartisan Commission on Comprehensive Health Care. Founded in 1890, NALU is a federation whose members are 1,001 state and local life underwriter associations. The 140,000 members of these local associations are sales professionals of life and health insurance and other related financial products. These members are actively involved in the sale of individual and group health insurance as well as disability and long term care products. To the extent that the Commission makes recommendations which are ultimately adopted by the Congress, the work of the Commission will be greatly felt amongst our members.

NALU believes it is in the best interest of the United States, both in terms of its responsibility to its citizens and its competitive advantage within the world community, to provide universal access to health care. As a leader among nations, the U.S. can no longer permit its countrymen -- whether they are insurable or uninsurable, employed or unemployed, middle class or economically disadvantaged, to be without health insurance coverage. In addition to the obvious humanitarian concerns involved, it is vital for our nation in terms of productivity and continued economic expansion to have a citizenry which enjoys 100% access to health care. As we contend with the new challenges presented by the Pacific Rim countries and the European Community in 1992, the U.S. can no longer take a backseat to its competitors, whether it is in the area of trade, or the health and well-being of its people.

The question whether ways should be found to provide health insurance coverage for the 31-37 million presently uninsured Americans is in many respects a rhetorical one. The answer -- which will necessarily involve the method of delivery, financing, cost containment, the respective roles of government and industry (including insurers), the relationship of hospitals and physicians to the complex system, is complicated in the extreme.

Defining the Problem

Initially, we would urge the Pepper Commission to take special care in defining the actual number of uninsured in the U.S. Previous data published by the Bureau of the Census (U.S. Department of Commerce, Bureau of Census, Current Population Survey, March 1987) and tabulated by the Employee Benefits Research Institute (EBRI), concludes that 17.8 percent or 37 million individuals have no health insurance coverage. This statistic has seemingly become gospel. The figure has been bantered about with little concern for its present accuracy by media and public policy analysts alike. However, more recent analysis of the same data from the Census Bureau have indicated that 31 million uninsured Americans is a more likely figure. A Department of Health and Human Services (HHS) economist, M.Eugene Moyer, reported that the drop was reflected from the "fact that the Census Bureau used more comprehensive questions in its latest survey on health insurance and located people who had been missed". It has become obvious that few can agree on the exact number. Before tackling the problem, it is vital that we know its parameters, because clearly that will bear on the ultimate, presumably enormous cost of any solution.

Employer-provided coverage

Employer-provided insurance is the largest source of health coverage. The U.S. Department of Labor's Bureau of Labor Statistics indicates that 95% of full-time employees in medium-sized and large organizations received employer-provided coverage in 1986. Only 65% of small employers, according to the National Federation of Independent Business's (NFIB) survey in 1985, provide similar coverage. Arguably, the success of employer-provided coverage -- at least for medium and large employers -- has been driven in part due to Section 162 of the Internal Revenue Code (IRC), the employer business expense deduction which permits employers to deduct as an ordinary business expense 100 percent of the contributions made on behalf of their employees for health benefits. In addition, IRC Section 106, the employer exclusion, excludes from taxable income of workers all contributions made by employers to health plans. These aspects of the tax code have arguably been the primary incentive in extending health insurance coverage, along with the market conditions which induce corporations to provide such coverage in order to remain competitive in the employment market.

Mandated Health Benefits

Although employer-based coverage has been largely successful, NALU opposes the concept of mandating such coverage as envisioned in S. 768 and we urge the

Commission to reject the concept of a mandated approach. While we applaud the goals of those who offer such legislation, the public and private costs seem to discourage the adoption of this well-intentioned proposal.

According to the Institute for Research on the Economics of Taxation (IRET), costs to employers under a mandated program are estimated at about $1,600 per employee, with total costs reaching nearly $100 billion. The Congressional Budget Office (CBO) estimates the cost of such an approach to add $27.1 billion to employment-based plans.

As the National Chamber Foundation points out in its recent study -- Mandated Benefits for Employees: A Policy Analysis -- "the drive to mandate more benefits would add rigidity to the work force and raise labor costs at a crucial time when greater flexibility in the use of labor and moderation in labor costs are clearly warranted by competitive economic conditions. Thus, we face a policy dilemma -- mandating benefits, the most immediate and direct response to a lack of health insurance among workers, is precisely the approach that would be least appropriate to maintaining the viability of many jobs and enhancing economic growth. By contrast, some private sector approaches pose less threat to attaining our economic goals, but are slower, less direct, and possibly incomplete ways of meeting the lack of insurance coverage."

Solving the Needs of the Poor and Working Poor

The major problem of the uninsured seems to lie with the poor and near poor. According to EBRI, "about 21% of nonelderly people in poverty (6.4 million) had some kind of coverage in 1986, and 13 percent (3.9 million) had health insurance from an employer. This compares with 82.7 percent with some kind of private coverage and 74.6 percent with coverage from an employer plan among the nonpoor population". These individuals have generally received coverage, when covered at all, through such programs as Medicaid, Medicare, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), or the Civilian Health and Medical Program of the Veterans Administration(CHAMPVA).

Solutions to Avoid: The Canadian System

A recent article in the National Journal (7/22/89 by Julie Kosterlitz) begins jokingly: "Tell President Bush he needn't bother creating a kinder gentler America, because it already exists: It's called Canada." Though our brethren to the north seem to offer a system which is more complete and less of a patchwork quilt under which we operate, and appears to be more compassionate, its flaws are notable and offer important lessons. While its universality is attractive, the Employee Benefit Research Institute (EBRI) (EBRI Issue Brief -- Canada's Health Care System: Lessons for the United States? May 1989, No. 90) points out some critical areas which would be incompatible and unacceptable to an American health care system. Its reputation is one which is seemingly unable to respond to continuing innovations in technology, with spending constrained to hold down the costs of health care. While health care in

Canada consumes less than 9 percent of its Gross National Product (GNP) compared to over 11 percent in the U.S., its savings mask critical health care supply shortages, increased dissension between physicians and provincial governments, a frequent shortage in hospital beds, excessive waiting periods for patients to be treated by physicians (especially for elective surgery), cost shifting, and a high level of government involvement. While its first dollar coverage and reputation for basic access are enviable, as EBRI indicates in its study, an administrative system driven by political and regulatory motives instead of price changes and profit incentives is one which is unlikely to work in the United States.

Solutions

Clearly, the private insurance market has proven successful in providing coverage for those Americans who can afford the premiums. Regrettably, we are less successful in assisting those who are less fortunate. Instead, public programs have attempted to fulfill a rapidly expanding need. Unfortunately, the dollar amounts necessary to finance programs such as Medicaid have been insufficient. Categorical standards and state-imposed restrictions have left any economically disadvantaged individuals out in the cold, unable to receive vital medical care.

What can be done to fulfill this need? Private carriers will be unable to provide any effective assistance without government intervention, at least in terms of delivery to the poor and near poor. One alternative is through the enactment of effective tax incentives. Tax deductions, or preferably refundable tax credits, will go a long way toward helping the indigent to purchase the insurance coverage of their choice. While employer-based coverage has been successful in providing a broad base of the population with benefits, it is unable to reach those who are unemployed and poor. Instead, a refundable tax credit would be more effective and less discriminatory towards those not currently in the workforce. One option which has been discussed allows taxpayers to adjust their withholding to reflect the anticipated tax refund. In this manner, an individual could use the tax subsidy on a more immediate basis and pay for the health insurance premiums as incurred.

Another possibility is the bill proposed by Senator Lloyd Bentsen (D-TX), S. 1185, the "Child Care and Health Insurance Act of 1989", recently passed by the Senate. Phased in over five years, the legislation provides families earning $12,000 or less half the cost of a $1,000 premium. Families earning $12,000 to $18,000 would receive a smaller credit. Legislation of this type would be very helpful to lower income families while utilizing the private insurance market.

Other alternatives such as the one introduced by Representative Bob Carr (D-MI), H.R. 1422, increases to 100% the amount of health insurance costs which may be deducted by self-employed individuals and makes such a deduction permanent.

These legislative initiatives, and others like them, are some of the appropriate measures which Congress could consider, using the present structure of our health care system. NALU believes that a multipartite approach would go far in bringing more individuals into the health care system which should ultimately result in the universality which we espouse.

Those who can be covered by private insurance should be encouraged, whenever possible and through appropriate tax incentives, to obtain such coverage. However, if an individual is unable to maintain private insurance due to preexisting medical condition(s) or other underwriting considerations, or because appropriate individual coverage is unavailable, unaffordable by a person who works for an employer that does not offer group health insurance, a second alternative should be utilized -- namely, through risk pools.

Coverage should be available through state or regional risk pools which fully spread the risks associated with insuring those persons who cannot otherwise obtain coverage. This risk spreading amongst the general population, should include reasonable premium payments by participants. If a person cannot afford or otherwise qualify for coverage through such state or regional risk pools, government intervention is required.

As a last resort, coverage should be available through expanded Medicare or Medicaid programs. NALU believes that society as a whole is ultimately responsible for making sure that its poor have access to quality health care.

Joint efforts by private industry, federal, state and local governments are required to solve this national crisis. No one entity can do it by themselves. Though it is easy for industry and government to incriminate one another for their lack of response, it is time -- no it is past the time -- to begin working together in an effort to find the answer to the problem. Government and business sectors must join to assist those who cannot fully pay their health insurance tabs out of their own pockets.

Let us continue to examine innovative strategies such as the various uses of life insurance. Ideas which include the acceleration of payment of life insurance benefits for victims of Acquired Immune Deficiency Syndrome (AIDS), using life insurance to pay for long-term care benefits, and others which the industry through the assistance of government via favorable tax treatment can employ to facilitate greater access to health care.

An examination of the disparate state guidelines for Medicaid may be useful. Those who might meet the categorical standards may be nevertheless ineligible due to income restrictions or other standards. The Congress should consider a careful review of the Medicaid program and appropriate sufficient funds to meet the needs of those unable to take advantage of private insurance or risk pools.

Any program which seeks to solve the nation's uninsured problem must include a cost containment component. The Prospective Payment System (PPS) must be reviewed with an eye toward reducing unnecessary regulations which hamper the effective delivery of health care and needlessly increase its cost. While the goal of a PPS system -- to provide hospitals with an explicit set of payment rates determined in advance -- is an admirable one, the program should nevertheless be adaptable to changing technologies and responsive to excessive regulatory burdens.

Increased use of case management, preadmission certification, additional coinsurance and deductibles to encourage self-insurance where appropriate, and the availability of Multiple Employer Trusts (METS) may all prove vital in the cost containment equation.

These strategies, though not all encompassing in nature, offer what we believe to be an excellent beginning. The private sector does not have all the answers. However, we can be part of the mechanism by which to solve the nation's uninsured problem. NALU urges the Pepper Commission to develop a system, perhaps along the guidelines suggested here, which utilizes the present private health insurance system without resorting to a new and cost prohibitive national health insurance program.

Chairman **Rockefeller**. Thank you very much, Mr. Irons. Mr. Havens.

STATEMENT OF SAMUEL HAVENS, FINANCE COMMITTEE CHAIRMAN, GROUP HEALTH ASSOCIATION OF AMERICA, INC. [GHAA]

Mr. **Havens**. Thank you, Mr. Chairman. GHAA is the oldest and largest HMO association in the United States and represents over 20 million members. GHAA member organizations include those also which sponsor and are developing other forms of managed care systems. I urge this Commission to recommend the development of a national health care policy based on the principles of sound managed care systems as a cost-efficient means of maximizing access to quality health care for all Americans.

Most policymakers and other experts on U.S. health care seem to have recognized that a Government run and financed health care system is not a viable option, principally because of budgetary constraints. However, access and cost-inflation problems continue to escalate and are approaching the point where a national response is required. Critical to that national response is addressing the problem of health care costs. Containing costs will help improve access to the system.

The solution I recommend is currently working in the marketplace and preserves what is best about our current system, consumer choice, competition, and dedication to high quality of service, managed care. The rapid growth of managed care over the last 10 years has already had a positive impact on health care.

The success of the HMO industry has contributed greatly to our knowledge of managing the health care delivery system. The response to the competitive challenge from HMO's has been the development of new reimbursement mechanisms, greater consumer choice, better programs for quality assurance. This evolution is continuing into newer forms of integrated managed care plans.

The 1980's saw the rapid growth of the familiar HMO dual choice arrangement. In the 1990's point of service managed care plans, which provide incentives to consumers through the continuous option of using cost-effective managed systems, along with traditional HMO's, will represent the majority of health care benefits. Organized networks and group practices of physicians will manage the care and compete for patients on the basis of quality and cost effectiveness.

Obviously in any approach to addressing access to health care for the general population, including the uninsured, cost is always an issue. HMO's and similar managed care organizations have a well documented track record on holding down cost. Between 1987 and 1988 the premium increases for HMO's, group and staff models was half that of traditional indemnity insurance.

The phenomenal growth and acceptability by the public and private purchasers should not be ignored and amply justifies new policies based upon managed care principles. Companies like mine have already made a major commitment to move from emphasis on indemnity programs toward managed care. It is a plain and simple recognition of the realities of the modern health care economy.

In the early 1980's our employer-customers' concerns over health care costs greatly escalated and HMO's grew dramatically. Employers then introduced the use of managed care techniques that were then available in the indemnity plans, such as second opinion surgery, utilization review, and preadmission certification. As insurance companies, in concert with their employer-customers, struggled to address the cost-containment issue, it became patently clear that the existing techniques, while useful, would never do a complete job working within an indemnity environment.

We were experiencing a fundamental change in the nature of the health insurance business. Our employer-customers were asking us to help their employees select their health care providers, provide them with the assurance that they were receiving high quality of care, and that the care was delivered in the most appropriate setting. In other words, they were asking us to manage the health care system on behalf of their employees. This is a very familiar concept in the HMO field. Employers are now, for the first time, prepared to insist that their entire health care plan be managed in a fashion like that of traditional HMO's.

It is extremely important that this Commission and others recognize how essential an appropriate regulatory environment is to the success and survival of these managed care systems. We have become victimized by mandated State benefit requirements, which are attributed more to the lobbying power of provider interest groups than genuine health care needs. State-mandated laws should be preempted by Federal legislation. In addition, some States have enacted or are proposing legislation that will impose barriers to the operation of effective managed care plans. These laws include those that impede effective benefit design, selective contracting with providers, utilization review, and the use of primary care physician managers.

We urge the Commission to adopt, as part of its recommendation, that such barriers should be avoided or eliminated and we strongly urge that the Commission recommend a national policy with greater reliance on managed care to organize a cost-effective delivery system. I realize that this brief statement is not sufficient to fully explore the course I suggest. Please be assured that GHAA and its member plans will cooperate with the Commission and its staff in its important work in developing solutions to the consequences of access and cost barriers to needed health care for Americans. Thank you.

[The prepared statement of Mr. Havens follows:]

STATEMENT ON BEHALF OF THE

GROUP HEALTH ASSOCIATION

OF AMERICA, INC.

SAMUEL HAVENS

SENIOR VICE PRESIDENT

PRUDENTIAL INSURANCE

COMPANY OF AMERICA

BEFORE THE

PEPPER COMMISSION

ON

ACCESS TO HEALTH CARE

OCTOBER 24, 1989

WASHINGTON, D.C.

EXECUTIVE SUMMARY

- More than 32 million people are enrolled nationwide in HMOs.
- By managing care, HMOs and similar organizations are able to control costs while providing high quality comprehensive health services.
- Growing acceptance of managed care concepts has occurred with the experience of the federal government through Medicare, state government through Medicaid and with private employers as they have increasingly turned to managed care to deal with sharply escalating costs.
- Costs have risen more slowly in HMOs than in the fee for service sector. From 1987-1988, HMO premiums increased half of that of traditional indemnity insurance.
- Controlling costs and the out of pocket expenses to enrollees enhances access to care. In addition, the HMO management of care and emphasis on preventive services is important to populations which may have had problems with underservice.

Good afternoon:

My name is Samuel Havens. I am a member of the Board of Directors of the Group Health Association of America and Senior Vice President of the Prudential Insurance Company of America. I appear today on behalf of GHAA, the oldest and largest HMO association in the United States. GHAA's member organizations include organizations which sponsor or are developing other forms of managed care systems. HMOs enroll more than 32 million people nationwide.

The tenor of my testimony is to urge this Commission to recommend the development of a national policy based on the principles of sound managed care systems as a cost efficient means of maximizing access to quality health care for all Americans.

Most policy makers and other experts on U.S. health care seem to have recognized that a massive government run and financed health care system is not a viable option because of budgetary constraints. However the access and cost inflation problems continue to escalate and are approaching the point where a national response of some sort is required.

Those of us who have been involved with HMOs and similar kinds of managed care have always advocated an approach to health care reform which emphasizes efficiently organized private sector systems which provide cost effective quality health care in a competitive environment. The rapid growth of HMOs over the last ten years has already had a permanent effect on health care in America. The competitive challenge of HMOs is in some degree responsible for development of new risk reimbursement mechanisms and attention to quality assurance and oversight. HMOs have become a basis for a variety of initiatives and experiments which fall under the general category of managed care. Perhaps the most attractive feature of these programs has been our ability to continue to provide better quality, comprehensive benefits while containing costs, all with minimal out of pocket payments.

In any approach to addressing access to health care for the general population, including the uninsured or underinsured, cost is always an issue. HMOs and similar managed care organizations have a well documented track record on holding down cost--for government, private employers and individual and family HMO members. Between 1987 and 1988, the premium increases for HMOs, group, staff and IPA models, was half that of traditional indemnity products, including some with cost containment features.

These programs also limit out of pocket expenses to the enrollee. According to the 1989 GHAA HMO Industry Profile, 82 percent of the HMOs responding to the survey covered hospitalization with no limit and without other patient payment, while all plans covered primary care visits with no limit on the number of appointments. Approximately 48 percent require a copayment for primary care visits, usually in the 3 to 5 dollar range.

This private sector approach launched by the Congress over 16 years ago has proven its worth in making health care affordable and accessible.

Indeed, two of the most famous national health programs, England and Canada, are now exploring efforts to include competitive, organized systems of health care as alternatives. We would be foolish to discard a long and valued experience when others seek its advantages.

This and the previous administration have announced a policy of encouraging managed care as a preferred option under the Medicare program. Many of our GHAA member plans with Medicare risk contracts have had difficulty with the reimbursement formula, inappropriate regulation and related problems. But we are all encouraged by the good faith efforts of the Health Care Financing Administration to come to grips with the problems through open and candid discussion, proposed short term increases in the rate of payment and in the longer term, the development of a more precise reimbursement formula.

In spite of these problems, over one million Medicare eligibles have enrolled in the Medicare risk program.

States have shown an increasing interest in managed care programs, particularly in the Medicaid area. A half dozen states now have programs which mandate the managed care option in Medicaid programs. Our major problem here has been to steer state and federal officials away from the attitude that enrollment in managed care systems is desirable solely to cut costs. Rather they need to look at access, quality and the revenue needs of the plans. The commitment of the states is growing as state officials learn more about us and realize the inhibiting effects of arbitrary and unreasonable mandated benefits and unduly high financial reserve levels.

One recent study has concluded that state programs which provide private sector managed care options significantly broaden the number of providers available to the beneficiaries, therefore substantially increasing access to care.

We attribute the success of managed care mostly to employers and their growing interest in alternatives to the oppressive burdens of ever increasing costs. We have responded to employer concerns by providing more timely and relevant data, developing new structures, forms or, as the insurance industry call it, new "products". We have developed more flexible rating systems reflecting the use of utilization experience and demographic characteristics of specific employee groups.

Some national employers are now offering a range of options through a single entity or a through a network of a limited number of managed care systems. Point of service options which favor the managed care systems are growing in popularity. The recent settlements in major labor disputes are predicated on the development of managed care options which preserve comprehensive benefits.

Our phenomenal growth and acceptability by public and private purchasers should not be ignored and amply justifies new policies based on the managed care principles. Many of the large insurance companies have already made a major commitment to move from emphasis on indemnity programs toward managed care. This is a plain and simple recognition of the realities of the modern health care economy.

We urge that this commission view managed care as an integral part of proposed health care reform. We recognize that third party payment programs will always play a role and have their place so we are not arguing exclusively for managed care.

It is extremely important that this commission and others recognize how essential an appropriate regulatory environment is to the success and survival of our systems. Any recognition of managed care should include requirements in this regard.

Since 1971, when the national health maintenance strategy was first announced, we at GHAA urged that benefits not be mandated beyond the requirement of full inpatient and outpatient coverage with limited copayments, leaving sufficient flexibility to HMOs to set priorities or meet purchaser demands. Unfortunately, we have become victimized by mandated state benefit requirements which number over six hundred in the aggregate and which are attributed more to lobbying power than genuine health care needs. Our programs should not be forced to scale back needed benefits to offset the costs of these arbitrary mandates nor should their costs become another access barrier.

Some states have enacted or are proposing legislation which would require that providers be paid on a fee for service basis, that all providers in a community be permitted to participate in the program, that only retail pharmacies be used, that high reserve requirements and guaranty funds be maintained. These and similar restrictions undermine the ability of the HMOs and similar systems to manage the care of their members and efficiently operate their programs.

We are convinced that most of our regulatory difficulties stem from a failure to recognize the major difference between our programs and fee for service third party payment. We manage our health care services and assume risk for provision of benefits. We do not pay claims except for out of area and certain in area referrals. We are able to provide broader benefits because of the efficiencies inherent in an organized system. We should be viewed and regulated in this light rather than as claims payors.

I realize that this brief statement is not sufficient to fully explore the course I suggest. Please be assured that GHAA and its member plans will cooperate with the commission and its staff in its important work in developing solutions to the tragic consequences of access and cost barriers to needed health care.

Thank you.

Chairman ROCKEFELLER. Thank you, Mr. Havens. Mr. Hunter.

STATEMENT OF J. ROBERT HUNTER, PRESIDENT, NATIONAL INSURANCE CONSUMER ORGANIZATION

Mr. HUNTER. I'm the last one, Mr. Chairman. I appreciate your patience, both of you.

Health insurance is supposed to be a bridge to security, so since I'm the last one I have to bring the analogy to route 880 after the earthquake because we have a system that's falling apart. The on ramp has collapsed and a lot of children are having difficulty, uninsured because of the income level of who they're born to. The off ramp has collapsed. We almost propped up the catastrophic part of it, but it's fallen again. The long-term care off ramp has never been open. And the group insurance concept is beginning to break apart, which has been sort of the main body of the bridge.

My small group, for example, recently received a letter saying that our new employees will be underwritten by Blue Cross/Blue Shield and that our prices will vary by age. My family of three now at home, in my age bracket, will pay $12,033 a year here in Alexandria, VA.

So, I would say that part of that part of the bridge—the small group part—is in pretty bad shape; 37 million Americans are trapped in the uninsured part of the bridge that's collapsed. And no one is really totally safe because the whole structure is in awful condition. COBRA helps, but for people who are really sick and really hurt, you run out of COBRA too. And this committee has the responsibility to be the safety engineers and architects and we need a review of the entire system. So, I'm really pleased that you're doing this.

Now, the breakdown of the group concept is startling and I go through that at some length. The regulatory control at the State level has been always weak. We hear the insurers lobbying for ERISA expansion because that's weaker and, in fact, the Department of Labor is totally unprepared to help consumers. And we encourage you to look very carefully before you consider expansion, at the mess consumers are in that are under those plans covered by ERISA. If an insurance company operates in bad faith, you have no access to court, no access to State court and those remedies; no State consumer protection. There are no real plans for handling those kinds of problems.

As we move toward national health insurance I encourage you to look at the comprehensive health insurance plan costing done under the Nixon administration. I was chief actuary to the Federal Insurance Administration during that time. I think it was very careful costing. I don't think there's any doubt that a good comprehensive plan, integrated at the national level, can save money. The problem is, a lot of that money may have to come through the Federal budget, or off budget, or however you do it these days.

It's not a resource issue, I don't believe. I think we'd spend less if we do it right. But the problem is, which pockets will it come out of and which rice bowls might get broken. And that's really what you have to deal with.

So, I encourage you to review the Federal programs very carefully, ERISA, the Medicaid, Medicare Program. Find the best ways to administer it. Do it ab initio. What is the best way to administer it? Look at the National Flood Insurance Program and its experience with contracted versus private insurance delivery and how much it saved. Look at the worker's comp plans in the various States and how the various levels of State control of the administration, how that impacts on costs. Review the State health plans.

We have to come up with a plan that gives access to health care to all Americans. Health insurance is the only insurance that every American needs.

You have some leverage that you must consider. When Congress sneezes, States blow their noses. You have great leverage at the State level. If you say there will be Federal standards and if a State does not meet them that regulation or other control will be lost by the State, you will find that the States will act. We found this in the advent of Senator Magnuson proposing insolvency funds. Just a proposal, in a strong way, led to action in every State to adopt insolvency funds. So, you have considerable leverage.

I encourage Federal standards for access, Federal standards for community rating for individuals and small groups. I hear a lot about community rating, maybe for small groups, but also we need to worry about individuals.

And so, you have a wonderful opportunity, sir, and as the last witness, I do encourage you to use it well and wisely because the problems are tremendous. So, good luck.

[The prepared statement of Mr. Hunter follows:]

NATIONAL INSURANCE
CONSUMER ORGANIZATION

STATEMENT OF

J. ROBERT HUNTER, PRESIDENT

NATIONAL INSURANCE CONSUMER ORGANIZATION

BEFORE

THE PEPPER COMMISSION

UNITED STATES BIPARTISAN COMMISSION ON

COMPREHENSIVE HEALTH CARE

October 24, 1989

121 N. Payne Street
Alexandria, Virginia 22314
(703) 549-8050

Mr. Chairman and members of the Pepper Commission, it is my pleasure to appear before you today.

In earlier days, during my time at the Federal Insurance Administration, I had the opportunity as Chief Actuary to work on the Nixon Administration's National Health Insurance Plan (CHIP) -- perhaps the last real chance we had for an overall solution to this nation's collapsing health insurance system.

You know all the chronic problems -- 37 million uninsured, vast numbers underinsured with partial protection (either on a disease basis, like cancer insurance, or a dollar basis, like $100 a day in hospital), the medi-gap abuses, the long-term care gap, the conversion problems partially plugged by COBRA -- the problems that leave all Americans exposed to possible financial ruin from a serious illness or accident.

And, if these well-known problems were not enough, some new serious problems are emerging:

(1) *BREAKDOWN IN GROUP CONCEPT*

As if desirous of following their auto insurance brethren over the edge of the cliff, the health insurers are rushing to break down the group concept. In the good old days, a group contract was community rated -- that is everyone in the group paid the same price -- and a group contract's coverage was available to all employees.

But now, this concept is being destroyed. Look at the attached letter of September 20, 1989 from Blue Cross/Blue Shield to NICO. There are at least three very interesting points in the letter:

(1) there will be underwriting of "any participant from (our) group whose coverage becomes effective during the new contract period" which could result in "permanent exclusion of benefits for conditions which existed before they enrolled" (emphasis added);

(2) the rates are based on age; and

(3) for my very healthy family of three, the annual charge is $12,033 (I leave it to you to calculate my age bracket).

Points (1) and (2) should be of immediate concern to this Committee because it is evidence of the end of group pricing and group underwriting. Point (3) is of great interest to me as President of a small group who has to fight hard to get dollars from contributors to cover these mounting monumental costs (like others in this situation, I am in the process of getting competitive quotes and looking at coverage changes).

Small businesses, unable to self-insure, are placed in a competitively disadvantageous place with this sort of change in the group concept; not only must they raise prices on their products or services more, relative to large competitors, but they can't attract certain employees because of the underwriting risk faced by new employees with any pre-existing conditions.

The fracturing of the group concept can only lead to more uninsureds and underinsureds particularly since some small businesses will surely not be able to afford this sort of cost. The auto insurance practices of redlining, unaffordable prices, etc., which has lead to a national consumer revolt in that market, appear to be being firmly rooted in our already tenuous health insurance market.

I do not fault the Blues too much for this. They are the last to do it and have even tried to hold off doing it, but their private carrier competitors have used the familiar tactics of cream skimming to force many Blues operations to the brink of insolvency, just as (in auto insurance) State Farm forced the old-line stock insurers such as Aetna to their knees and to engage in excessive market fragmentation as a "competitive" strategy.

(2) ***BREAKDOWN IN REGULATORY CONTROL***

State insurance regulation is generally regarded as weak. For example, in a recent Study of Insurance Department Operations, the Consumer Insurance Interest Group and the National Association of Professional Insurance Agents (an unusual coalition of consumer activists, including myself, and insurance agents) found:

* In most states, regulators lack the personnel and tools to properly fulfill their missions of providing adequate consumer protection and monitoring insurers for solvency.

* On average, less than six percent of the annual insurance premium taxes collected by states is spent on insurance regulation. Department funding represents less than one-tenth of one percent of overall state budget totals.

* The important function of consumer affairs is too often relegated to clerical personnel or entry-level professionals. Consumer complaint activities, therefore, tend to be passive, providing little in the way of actual redress for insurance consumers.

* Salaries for consumer affairs staff, actuaries and attorneys in insurance departments are well below national scales on average.

* The number of complaints received by insurance departments is staggering -- more than 23,000 per department per year on average. Only one-third of the state insurance commissioners interviewed have specific written procedures for handling consumer complaints. One out of three

departments still logs complaints manually.

- Only half of the departments maintain a ratio of complaints by insurance company. A majority of insurance departments has no formal system for sharing consumer complaint information with other insurance departments, although most do share information on an informal or as-needed basis.

- Nearly one-third of the departments reported they do not conduct market examinations. A large minority of departments which do conduct market exams does not have formal systems for triggering such exams, such as complaint ratios.

- Fewer than half of the departments conduct financial examinations on domiciled companies at least every three years. And four out of ten departments interviewed do not have the capability to retrieve statistical information on financial examinations.

We have called for increased funding and staffing as well as training to assist in this area.

The only thing that may be worse than the current state of state regulation is the current state of ERISA control which appears totally unprepared to help consumers. There needs to be a major increase in regulatory authority and staffing, if ERISA is expected to regulate effectively. Insurers seek expanded ERISA oversight precisely because it is not effective. At least when state regulation fails, individuals and businesses can go to state courts to seek, for example, payment of denied claims and damages for the bad faith the insurers have displayed. The U.S. Supreme Court has held (in Dedeaux vs. Pilot Life) that state court remedies are pre-empted by ERISA's provisions. ERISA allows few remedies in federal court other than possible payment of what was due in any event. No "bad faith" remedy exists, thus cutting off many victims of insurer wrongdoing from legal representation, particularly when the amounts involved are relatively low.

We now have a dual system of weak state and weaker federal regulation that has resulted in a regulatory drift as the entire health insurance system runs out of control toward some major catastrophe.

I believe ERISA rules should be changed to return all health insurance regulation to the states, consistent with the state regulation preference expressed in the McCarran-Ferguson Act. If we want total federal control with consistent rules, adequate staff and computers, etc., let's work on that. In fact, let's go all the way to National Health insurance soon. But until we move in an overall way, the situs of regulation should be the states.

(3) *BREAKDOWN IN COVERAGE*

In order to control their skyrocketing health insurance rates, consumers of insurance, particularly individuals and smaller businesses, are raising deductibles, taking on a larger percentage of co-insurance (both of which may be desirable) or (less desirable) excluding coverages, excluding pre-existing conditions or even excluding named individuals, all of which add to the potential of people falling through our unravelling safety net to their family's financial destruction. Further, insurers are offering more "nonguarantee issue" basic coverage (i.e., not promising the same policy will be issued on renewal of the group policy).

Where Are We In Our National Health Insurance Situation?

Let's be blunt. We have a disaster on our hands. Health insurance is often unavailable and/or unaffordable to individuals, including the self-employed, who often opt to "go bare". Small groups are no longer real groups. There is no regulatory leadership at the state level, but that lack of leadership looks good when compared to the federal vacuum.

What Can Be Done?

The breakdown of the insurance market -- the lack of service of "high risks" -- has happened earlier in auto insurance. (The one real difference is that auto insurance is not needed by every American, but health insurance is.) We have tried several ways to plug the gap in auto insurance:

- Some states use an "assigned risk plan" to service those not wanted by private carriers
- Some states have used a "Joint Underwriting Association" to service these risks
- Some have just required insurers to accept risks
- Some have coupled such a requirement with a "reinsurance facility"
- One state (Maryland) uses a state fund

The assigned risk plan works like this: as a condition of doing business in a state, the insurer must agree to accept, at a separate high risk rate that is usually not fully self-sustaining, a percentage of the uninsurables that is an equal percentage its voluntarily written insureds are to the total voluntarily written insureds. The unwanted risks are physically assigned to the insurer in a random way. The privity of contract is with the specific insurer to which a person is assigned. If there is a financial gain or loss in the overall assigned risk book of business, it is also apportioned to the insurers who charge off the loss to the voluntary market (creating as "cross subsidy").

The Joint Underwriting Association works in a similar way, but, rather than assigning people to companies, the policies are issued by syndicates of all the insurers. Servicing carriers are utilized to handle the claims. Any loss is spread to the voluntary market like in the assigned risk plan.

The requirement of insurers to accept risks is just that. It may be limited to "good" risks, per state definition of "good", or it may be a universal "take all comers" approach. This is like the first step in the reinsurance facility approach (discussed immediately below) but there is no reinsurance facility. The individual insurers must devise their own plans for spreading the costs of high risks.

The reinsurance facility is used to spread the cost of risks which are required to be accepted by insurers. Insurers may "lay off" (i.e., reinsure) any specific risk to a reinsurance pool of all licensed insurers, but the insured need not know that he or she has been so laid off. The rates are often the same as in the voluntary market. The excess cost of reinsured risks, if any, is borne by all insureds in the state, again creating a cross-subsidy from low risk to the high.

The Maryland State Fund is a sort of Joint Underwriting Association, but is administered by the state with insurer contributions if losses occur.

ANALYSIS OF AUTO PLANS

From the point of view of the consumer, the requirement of insurers to accept risks is the best way to handle the residual market. This integrates the market to serve all citizens. It can be coupled with a reinsurance facility or not and it can have a cross subsidy built in if needed. The advantage of the facility is that insurers can lay off excessive risk and are thus less likely to try to avoid the legal mandate to write risks by such tactics as pulling agents out of cities, application forms too complex to be filled out by the poor, etc. The disadvantage is that some insurers have advertised the cross-subsidy in a political attempt to play off the affluent suburbs against the cities. If this latter concern can be overcome, a reinsurance approach is feasible.

APPLICATION TO HEALTH INSURANCE

If we had political will and courage, I have no doubt that Congress would be at work on an overall solution to our Nation's health insurance mess -- via some sort of National Health Insurance Plan. Unfortunately, as we learned in the Catastrophic Care rout, there is little leadership, coverage, and will to save money if that means pay as you go. As to broader use of federal agencies or federal funds, I despair at any real solution in the near term.

However, there is hope. States want to retain their "control" of insurance. If Congress were to set some federal standards that would be implemented if the states failed to act, the states would act, I believe. States might move if given incentives to require all persons to be offered health insurance at some capped price (150% of the average large group?), with a reinsurance facility type of back-up. There should be federal standards requiring for community rating of small groups. The Congress should encourage creation of large groups made up of many small employers to enable efficiencies in Administration. Congress did this in the-liability insurance context (The Risk Retention Act) which allows both self insurance and group purchase by small businesses.

State regulation should be primary over ERISA (unless you significantly beef up consumer protection capacity, solvency controls, examination capacity, complaint handling, etc.). If we want to consider federal controls, you should do it on an overall basis so that the playing field is level between large and small employers. Those who would repeal delegation to the state under the McCarran-Ferguson Act bit-by-bit should reconsider. While I avidly support repeal of the outdated and outrageous anti-trust exemption, state regulation should not, I feel, be partially replaced until and unless we have the guts to replace it with something comprehensive and effective at the federal level. To set up a regulatory fiasco at the federal level is to poison the well for National Health Insurance. In other words, when all the consumer complaints of woefully deficient coverage, bad faith, etc., under ERISA come home to roost, National Health Insurance will be even harder to achieve.

CONCLUSION

It is inevitable that some form of National Health Insurance will exist in this country by the year 2010. The lack of political will will surely lead to a major collapse of our extant health insurance system. Some doctors are beginning to look to

Canada for solutions; even Lee Iococca is looking at some form of National Health Insurance. The consensus is building for genuine reform to replace our piecemeal efforts even though the insurance industry opposes real reform. Some form of pooling for uninsurables and small businesses is another patch, important, but not the whole answer. An overall overhaul of the entire system must occur.

1

Blue Cross
and
Blue Shield
of the National Capital Area

SEPTEMBER 20, 1989

MR. J ROBERT HUNTER
NATIONAL INSURANCE CONSUMER
ORGANIZATION
121 N. PAYNE ST
ALEXANDRIA VA 22314

RE: GROUP NUMBER P772
RATES EFFECTIVE: 12/01/89

DEAR MR. HUNTER,

After careful review of your group's subscription rates, we find it necessary to raise your monthly premium effective 12/01/89. We are taking this step because of increases this year in the cost and utilization of health care services in the Washington metropolitan area. The adjustment is based in part on your group's claims experience as well as the collective experience of other local groups similar in size to yours. Your monthly subscription rates for the coming contract period are attached to this letter.

Because we value your business, let me point out that there are several steps your group can take to help offset the effects of this premium increase. Depending on the type of coverage you have now and what modifications you make in the near future, your group may realize significant savings. I'd be happy to work with you, if you like, to reevaluate your existing benefits plan to identify what changes, if any, might be in your group's best interests.

In general, however, the following measures will cushion the impact of this rate increase. They include: raising your group's annual deductible, reducing the number of hospital days that are available to your employees or changing the level of reimbursement under your group contract for doctor's bills and other professional medical services.

In addition, please consider two new products Blue Cross and Blue Shield of the National Capital Area (BCBSNCA) has developed during the past year to help our customers contain costs.

The first is called Dual Option. With this product, your employees have a choice of joining a traditional indemnity plan, or selecting HMO-type benefits through BCBSNCA's affiliate, CapitalCare Administrative Services, Inc. Both options -- traditional indemnity and HMO -- are priced the same. That way, your employees can choose the type of health benefits program that best suits their family or individual needs, instead of making a decision

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based on price. Each option offers a comprehensive benefits package that includes hospital, maternity, well-baby and physician care, medical treatment in an emergency, outpatient diagnostic testing, laboratory services and x-rays. The two options differ in their out-of-pocket expenses and in the freedom of access your employees and their eligible dependents will have to doctors and hospitals in the Washington metropolitan area.

We also have another new product, built around our Preferred Provider network, that may save your group up to 15 percent. The Preferred Provider network is an arrangement between BCBSNCA and a group of 26 local hospitals and over 2,600 doctors and other medical specialists in the Washington metropolitan area. Because of our specially negotiated discounts with these providers, we can offer your group a less expensive alternative to the traditional indemnity plan you have now. Network subscribers may go to the doctors and hospitals of their choice, but they receive a financial incentive in the form of enhanced benefits and fewer out-of-pocket costs for using the Preferred Provider network.

Finally, to follow up on the Letter of Amendment we sent you in July of 1988, your group has been classified as medically underwritten for the contract period which coincides with this rate increase. This designation is based on the number of employees who were enrolled in your group at the time of our rate review. What this means is that any participant from your group whose coverage becomes effective during the new contract period will be required to fill out and file a medical history questionnaire with us before qualifying for covered services. As a result, these subscribers may be permanently excluded from receiving Blue Cross and Blue Shield benefits for conditions which existed before they enrolled.

I'd be happy to explain all these alternatives to you and compare rates so that you can decide which one is best for your group. Please call me at your earliest convenience.

Sincerely,

MURIEL MATHIS
Account Executive
(202) 479-8556

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Blue Cross
and
Blue Shield
of the National Capital Area

GROUP NUMBER: P7720000

MONTHLY RATES

AGE RANGE	SELF-ONLY	FAMILY
29 AND UNDER	$ 159.68	$ 371.42
30 - 34	199.60	445.70
35 - 39	239.52	519.98
40 - 44	292.74	705.68
45 - 49	345.98	891.38
50 - 54	425.80	1002.82
55 - 59	425.80	1151.38
60 AND OVER	425.80	1188.52
COMPOSITE RATES	239.52	1002.82

COMPLEMENTARY TO MEDICARE: $157.98

*** RATES SUBJECT TO REVIEW IN SIX MONTHS ***

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Chairman ROCKEFELLER. Thanks a lot, Bob. Dave Durenberger.

STATEMENT OF SENATOR DAVE DURENBERGER

Senator DURENBERGER. Mr. Chairman, thank you. Maybe just a comment. First, by way of a compliment to this panel and the others who often appear on panels like this, but aren't here.

When I was chairman of the Intelligence Committee I used to say that if I really wanted to know what was going on in the Soviet Union or how to change our relationships, I would go to Cargill. Not just because Cargill was in my State and it's the largest private company, I think, in the world, maybe the largest company in the world. But because they're in the sort of brokering business between people who grow things and people who need to eat them and that's one of the things we can't do without in the world.

And this panel sort of reminds me of a bunch of Cargills. I mean, all these folks are in the business, sort of in between our needs and those out there who need to provide them. And so, I have just a couple of comments or observations by way of, hopefully, soliciting some expansions on the testimony that we had today.

First, because in the period of time I've been involved in this I've watched traditional insurance companies become something else or at least a combination of something elses. I am tempted to ask the question for your written answers. Why, as we look to the long-term future of this company do we continue to use this concept of insurance as our way of accessing people to health services, plus illness and injury services, plus catastrophic financial protection? There are other things out there other than insurance to do that.

It may be that the model of what this committee needs to recommend by way of universal health coverage is a health plan in which people, like many of the insurance companies here, actually manage my access as a consumer to health care. How do you stay healthy? And whatever we debated at our last private meeting about minimum benefits, well, part of it is to say, well, the mandate will be for health, staying healthy stuff.

Then, the second thing that you people provide folks is this ill and injured plan. What do I do when my health fails me? Here you're starting to get somewhere between managing access into the system of providers and the insurance concept, but you're not necessarily there yet. Because all you're doing is matching me up with a good doctor or a good nurse-midwife or whoever it may be in the system because I'm going to have a baby or I am sick or I had an accident or whatever.

The third function that we seem to be buying, when we buy our FEHBP [Federal Employees Health Benefits Plan] or whatever, is protection against financial catastrophe. And the biggest problem in America, I think, is that nobody sells that particular product. Some people sell it as part of other things. But most people buy health, that is, I want you to pay me to go to the dentist and have him tell me that I ought to brush my teeth every day, or illness and injury, which means I can smoke myself to the verge of death and then you will pay me to get a new heart. We don't even mandate the most effective insurance in this country, and that is protection against financial catastrophe.

You all need to help us to look at those three kinds of components to what people need out there—and they all need it. We all need one or the other or all of these in a lifetime. Maybe you can suggest to us, as we approach the second point I'd like to make, how to do it better.

And the second one—I think Mr. Hunter just brought up and others may have—and that is the issue of the role of the Federal Government and the State government. And we've all, I think, agreed we ought to get rid of the State mandates, benefit mandates, and that sort of thing, because they're so costly and they fall inequitably across the population. But I think we need some advice on how to go about that process.

I mean, Federal standards and then the State, perhaps, qualifies individual plans to meet those standards, or something like that. Perhaps all of you could, in some way, make some recommendations to us and then to the insurance agents out there who always fight this sort of thing. Explain to them that not everything we're doing is insurance anymore. Maybe you could help us talk to them about splitting this apart. Let's have Federal standards for a lot of these things and that will leave the State to qualify individual plan providers.

And the third is the most difficult and some of you are working on this to varying degrees. And that is the whole issue of risk and how to spread the risk for the disabled and a lot of other people in this society. And it seems to me that somewhere along the line I've been anticipating HCFA [Health Care Financing Administration] will tell us, on the Medicare demonstrations, how to do an actuarially determined, dollar denominated, age, sex, and previous health condition amount, that we can allocate to each one of these people. Then we don't have to worry about adverse selection nor do we have to worry about dumping certain people into pools and things like that.

That if you can spread your particular part of the market broadly enough, and there are different payments coming from the employer, or from Medicare, or Medicaid, for different people based on their age, their sex, their previous health condition, and then maybe something that we used to call average community health costs—which in our physician payment reform bill I think we're calling cost of practice indexes or something like that. But I don't know where the industry or anybody else is at in trying to wrestle with a dollar denominated, let's call it a premium or a membership fee or whatever it is, that would be based on things we, you in particular, know a lot about in terms of susceptibility to health failures and susceptibility to needing certain kinds of procedures.

So, those are—as you were all testifying—those are three gaps in mine. I can't speak for the rest of the Commission, but three gaps in my understanding of where insurance, in the broadest sense, might make a greater contribution to the universality of our health coverage and also to the 15 of us, trying to come to some conclusions about what to recommend in terms of who we use to do what and the system.

So, I promised the Chairman I was only going to take 1 minute to say that, but that's—if it's possible for each of you to react in some way to that, not necessarily now unless you have to because it's past 1 p.m., but in writing, it would sure be helpful.

Chairman ROCKEFELLER. You should go ahead and respond if you want. I'm going to ask some questions.

Mr. IRONS. Mr. Chairman, if I might just respond to one remark that was made, and I would be remiss if I did not react immediately. You made a comment with regard to insurance agents fighting this thing. Mr. Vice Chairman, I would say that that is a tremendous misconception that abounds in this town that I've run into on numerous other speaking——

Senator DURENBERGER. Oh, it's no misconception. I've been sitting here 11 years——

Mr. IRONS. Well——

Senator DURENBERGER [continuing]. And every association—and they're all my good friends—every association of insurance agents tells me to keep the Federal Government out of the insurance business. I mean, that is no misconception.

Mr. IRONS. Well, no, then I misunderstood your question. I concur with that and I'll tell you why. As a State legislator, Mr. Vice Chairman—you made another comment about everyone agreeing to get rid of State mandates. Our State mandated prenatal screening in group health insurance. We were able to prove the cost effectiveness of that 16-cent increase in the monthly group insurance. So, I think to say that mandated benefits should be totally eliminated is throwing the baby out with the bath water. I think, really, you should analyze them on a State level.

The other thing that I would make very clear, from our perspective, is that the health insurance problems of Iowa are tremendously different than they are of the State of New York or the State of Rhode Island. And we as health and life insurance agents believe, quite correctly, that this control should be in the lowest level. The Federal Government has transferred so much of the cost of government to the local and State level that we believe we know, we sit in the homes, we sit in the businesses, we know the problems, and we want to work with you, as our testimony indicated, to work in a joint partnership to solve this. But from the Federal level down, to say that mandates are totally wrong, I think is not really analyzing what many of the mandates are.

And the other comment that was made by one of my colleagues that I disagree and find interesting, is that special interest groups on the local and State level have been able to accomplish this. Special interest groups also abound in this town and there will be no different outcome if it should be a Federal level. But I think it will be a much less understood, as to the point of application, which is what health care is all about.

Senator DURENBERGER. Thank you.

Chairman ROCKEFELLER. Are you satisfied?

Dr. SCHRAMM. Mr. Chairman, I'd make a comment on one thing. Actually, since Senator Durenberger brought it up, I can't help but point out, it is curious—I think I've probably testified on financing issues, financing issues alone, in my 2 years in this job, always on the very last panel.

Chairman ROCKEFELLER. You know, that is an interesting point, isn't it? It's a form of discrimination, deliberate, calculated, and cold hearted.

Dr. SCHRAMM. Thank you, Mr. Chairman. You've confirmed my worst suspicions. Senator Durenberger has asked a question, that obviously is also of concern to another member of the Commission who asked an acute care provider a few minutes ago, what do we do about this worsening situation of infant mortality, the only, albeit crude, indicator we have that's accepted in terms of the health status of this population. If you gave us more resources, we'd make the society better. I don't believe that for 1 minute.

We really are about the job, and you are about the job, fundamentally of how we make the society healthier more efficiently. And we get sort of caught in the crossfires because our traditional role has been to finance the care. That is what insurance has been. And I think our testimony today, certainly Mr. Havens' testimony, really is a story about the metamorphosis and that's Barney's testimony too, about what health insurance is.

And we are moving on a very painful route internal to us, of moving from indemnity, which basically pays you for whatever you think you need and your provider says you ought to have, to the troublesome—from our perspective it is a very tough cultural change—of finding ourselves in the position, largely because no one else is leading us there, but by exigencies of the marketplace—of imposing discipline on the provider system at the behest of our customers. That's what managed care is about. It is a very vigorous and tough and hard transition to be about.

But indemnity, as reported in our membership records of 1988, represents little over 25 percent of what insurance is in this society anymore, with managed care being the balance. And I think, if I might abstract some of what Sam said, you ain't seen nothing yet regarding the evolution and metamorphosis of managed care.

Mr. HUNTER. Mr. Chairman, just one thought. Insurance does two functions. The insurance premium dollar, builds a common fund that people contribute to, the ratepayers contribute to. That is the fund from which claims are paid. The two functions of what we call the insurance companies are to control who gets into the pool (for instance based on the condition of the applicant). And the other function is to control who gets to draw down on the common fund. There may need be some sharpening in terms of how that drawdown occurs. But the flow is relatively simple and I think the country is moving to end this first underwriting factor in some way. And that, obviously, conflicts with private insurance to some extent unless you can come up with a reinsurance or some other mechanism to back it up, because private insurers are going to try to avoid high risks. That's how they maximize profit.

Mr. HAVENS. Mr. Chairman.

Chairman ROCKEFELLER. Yes.

Mr. HAVENS. Could I make just a comment on Senator Durenberger's first point? In looking at those three elements, preventive services, illness and injury, and catastrophic, of course, the coverage side of that has been contained historically in the traditional HMO coverage. It is my feeling that that type of coverage, together with a link to an organized system—the two together, not one without the other—but an organized system together with the three elements of coverage that the Senator described, are not only out there now and working, but because corporate America is so concerned about the health care costs that they are for the first time beginning to adopt such programs or programs similar to these for all of their employees. And this is going to make a radical change in the cost side and the access side of health care in the United States.

Mr. TRESNOWSKI. Let me just——

Chairman ROCKEFELLER. Yes, Barney.

Mr. TRESNOWSKI. I just don't want Senator Durenberger to leave without thinking that I don't care about him. I am impressed, again, by Senator Durenberger's sophistication on the subjects in our business and we will respond to the issues that you raised. We're going to also tell you, in our response, something else that is deeply concerning me. And that is that we face, in our society today, in this industry, some very fundamental contradictions by the various players. I was impressed by Senator Rockefeller's comment earlier this morning about all of us having to share some pain. I think that's very true.

There are fundamental contradictions by the consumer, the employer, Government, the insurers, the providers. And as a recent editorial in Newsweek magazine pointed out, we deal with those contradictions by denying them. And I think a fundamental role of this Commission is to take those contradictions and surface them and say, now, let's get together and find out how we can resolve these contradictions. And I'll offer some comments to you along those lines. Thanks.

Chairman ROCKEFELLER. A few specific questions. Barney and Carl, I might aim this at you two. In your testimony, and I think also in Mr. Irons', referred to the uninsurables, uninsurables. And in a sense, almost as if they were—you know, there was some force out there which says that these people are not insurable. Yet a number of those people were being insured by you a decade ago and are not being today and why is that?

Mr. TRESNOWSKI. If you read carefully my testimony, we talked about voluntary State risk pools and the reason we advocate voluntary State risk pools is we think that each individual State needs to evaluate exactly the question that you're talking about. In fact, a lot of the Blue Cross/Blue Shield plans do insure the uninsurable.

I was impressed this morning by Mr. Monson, who represented the Citizens With Disabilities, commenting on the fact that diabetics couldn't get insurance. And he did point out that there was some available in the State of Virginia, but it was totally inadequate. I had a member of my staff go check the Blue Cross/Blue Shield plan on that point and what we found was that the plan does offer a very good product, a very comprehensive product for disabled individuals. One of the products has a $300 deductible and the other a $750. It covers inpatient and outpatient services. It's got a maximum out-of-pocket of $2,500 and it's got a lifetime maximum of $1 million.

Now, that's just picking out an example that happened here this morning. And the reason we say voluntary risk pools is a lot of the

Blue Cross/Blue Shield plans are insuring uninsurables and you shouldn't create something that's not needed in a community where it's there.

Also the way they finance these risk pools is they pass the hat, as Carl said, among all the insurers. We have a concern about that. If we're already providing broad coverage to uninsurables and you set up a risk pool, you pass the hat and we get double dipped. We're already taking care of a segment, then we have to pay again to reimburse the fund.

So, our sense is that, yes, it has changed in recent years. But we think that Blue Cross/Blue Shield still has an important role to play in covering uninsurables.

Chairman ROCKEFELLER. But I want to get into the parameters of what you've said. I mean, you've said, yes, that some of these things do exist. But, no, in that specific case it doesn't exist. And yes, that we in Blue Cross and Blue Shield—we think that we have some answers. I mean, what are you saying, Barney? There are folks out there who were insured or insurable, let's say, 10 years ago who are not insurable today. Or are you disagreeing with that, in fact?

Mr. TRESNOWSKI. I think I'm disagreeing with it. I'm saying in the example we are using, in Virginia, that those products are available and they're purchasable. I used the example of the diabetic because the individual said he looked at it. He said it was an inadequate product. Now, that's all in the eyes of the beholder.

It's inadequate if the person doesn't want to pay deductible. The product is there if you want to pay the deductible. Or he doesn't like the $1 million lifetime maximum, or the $2,500 is more out-of-pocket than he cares to pay. The products are there to be bought. It depends on what the individual wants to pay for it and whether it's something that he finds satisfactory.

If he doesn't—if he doesn't like it, then he's looking for something much more comprehensive and that's where the risk pool comes in. Where the risk pool sets up a product that is essentially free of deductibles and coinsurances and it's got a maximum of, say, 150 percent of the premium rate.

Chairman ROCKEFELLER. Would you want to comment on that, Bob?

Mr. HUNTER. As I understood your question, I understood there were people who were insured who maybe became very sick and then lost their insurance later. Some of these policies are guaranteed renewable, but in groups you end up with the conversion privilege and, you know, the COBRA protections run out after 18 months and it depends on your conversion privilege what you get. And that could be very inadequate. So, there are people who can fall through significant cracks in the current system, who were, appeared to be very good groups although COBRA helps on that.

Chairman ROCKEFELLER. Carl.

Dr. SCHRAMM. Senator, I hear you asking a question that has not been answered. And I would take a stab at it as follows. We insure people today who 10 years from now may appear uninsurable because of a breach of employment or something. These are people who today may not be in a high risk situation, but who may develop something and then have a termination of employment, and find themselves without insurance. And be in a situation, most likely poverty, where they wouldn't be able to buy individual coverage.

I would say that there are people who 10 years ago had insurance and now find themselves without insurance and we might declare them to be uninsurable because of a preexisting condition, something that's developed in that period of time. Let me say that there are very few instances where people are in a group, next to no instances, and are somehow selected out and thrown out of employment or thrown out of an insurance situation.

This is much more a development of the life process where they find themselves, unfortunately, coincidentally, getting worse in terms of some preexisting condition and then unemployed without a connection to an insurance plan. And I think that's what our design is in terms of these pools for uninsurable individuals. People who find themselves uninsurable, can they get insurance?

Chairman ROCKEFELLER. Well, I guess what I'm trying to get at too is, there is a general feeling that we've heard in private and in public that, you know, it used to be the community rates and the risk was shared across. Then gradually the Blues started and then competition came and then people started going for niches and drawing distinctions between those young and healthy as opposed to old and fragile and the difference between their being able to get insurance. But that seems to be fairly well understood to be a problem. And I don't know whether you gentlemen would agree with that or not.

Dr. SCHRAMM. Well, in a theoretical way, underwriting rules would take you in that direction. The fact is, I think the description of that as a reality is very, very much overblown. The vast majority of people who are covered are covered in large group plans, where the plan is blind to any underwriting situations whatsoever. That just isn't the reality out there.

Now, in fact, as people describe themselves playing in niches and there's a very small number of insurers who actually do that. Barney's plans basically can't do that by their market division, their geographical market division. They take everybody. Most of our companies are huge plans which describe their niches as marketing rules. They cover 50 or fewer cases, 50 to 100 cases or all comers, small plans or big plans or what have you.

But even in response to that, part of the charter to our board committee is to look at a mechanism whereby somebody who is in a group plan, who then develops a medical condition, that they would find, if they were unemployed, would be disabling in terms of being able to qualify again for insurance, could still obtain either individual insurance or group insurance. We have to come up with a mechanism where essentially the insurer is blind and without economic incentive to search that information out. That's what a reinsurance mechanism is designed to do. To essentially not discriminate on risk in the sense that people are excluded altogether from an insurance vehicle.

Chairman ROCKEFELLER. Carl, both you and Barney have said that your groups are looking at recommendations on community rates, et cetera, to deal with real problems. What are you considering and when might we know about it?

Mr. TRESNOWSKI. Well, in our case, as I indicated in my remarks, we're looking at the very question that you're identifying here and that is, to what extent can you reestablish some form of risk pool, community rate, something along those lines. And one way to do that, of course, is to get away from—whether it's real or not Carl and I can debate later on—the competition based upon risk selection. And whether there ought to be some rules for the players that makes the competition based upon the effectiveness of the delivery of the product, the cost containment that you do, rather than the underwriting rules that you apply.

Now, as Carl says, his group is looking at something along the same lines. That's very painful. It's painful because with an insurance product, if you're going to stay alive, you've got to look at the question of underwriting. And in the health business that's a tough thing to do, particularly given the fact that we're just coming out of a down cycle in underwriting losses.

But in a more theoretical sense, if we're going to solve the problem that you're describing, we've got to stop competing on risk. We've got to start to equalize our ability to cover risks and then compete on the basis of our effectiveness.

Chairman ROCKEFELLER. Let me ask another question, sort of for the record. And Mr. Irons, I think you have answered this one fairly clearly, so I might ask each of the four of you to comment. If you have an official position, obviously, that's helpful. If you don't, then respond as you can.

A variety of groups have made one of two proposals and obviously you've seen these in legislation already. A mandate that all employers provide insurance to all employees, No. 1. And 2, sort of a pay or play option where you either provide the insurance, or you are taxed to the extent that you don't in order to pay through some other form those who don't have it. What are your positions on that?

Mr. TRESNOWSKI. Let me comment on that first, if I may. The mandate, of course, is something that we're seriously looking at, at the moment and, as I indicated earlier, a mandate that's joined with a cost-containment strategy is one that makes much more sense to us. The tax idea, I think, is very troublesome.

Chairman ROCKEFELLER. Is very what?

Mr. TRESNOWSKI. The tax idea is very troublesome.

Chairman ROCKEFELLER. Troublesome.

Mr. TRESNOWSKI. Because what you're doing is, you're saying to the employer either you provide the coverage or we're going to tax you and then we'll go into a pool and we'll take everybody and put them in this risk pool. That's buying an opportunity for a pretty heavy regulation of the industry, No. 1. But No. 2, what you're going to find is that you're providing an incentive for employers to give up providing health insurance coverage and pay the tax and push everybody over into the pool. And I don't think that that really is——

Chairman ROCKEFELLER. Depending, I suppose, at what level you put the tax?

Mr. TRESNOWSKI. Well, that's right. But the leadership commission idea had it at such a level that it, indeed, did represent an incentive to move people into the risk pool. And I don't think that

that's good public policy to put people into risk pools. You know, you'll wind up with the risk pool covering everybody—every employed individual. And then you've got a totally regulated system under that circumstance.

Chairman ROCKEFELLER. Barney, why does that inevitably work that way? Why does everybody end up being in a risk pool because the employer chooses to pay the tax rather than——

Mr. TRESNOWSKI. Well, because you start in the risk pool, you start to push a segment of the population over there and you find that it's very expensive. The risk pool has got all kinds of things in it that are selected against and so on. So, you want to enlarge the risk pool, in order to broaden the risk, in order to diminish the cost. And pretty soon you build all kinds of incentives in, in order to make the risk pool credible and it's just kind of an inevitable thing that happens.

And as a matter of fact, if you look at the Canadian experience, the Provincial structure started that way. They created risk pools for uninsurables. They found out that it was too expensive to finance, so they enlarged the risk pool to take in other individuals. Found out that it still was too expensive and they enlarged it further to take in others. And pretty soon they had the entire population of the Province included in the risk pool. And then they said, gee, look what we've got here. We don't need a private insurance industry anymore.

Chairman ROCKEFELLER. Carl.

Dr. SCHRAMM. Senator, we're opposed to the concept of a mandate. And I should say that apart from the disemployment effects—which I believe are real—and the Congress in the appropriate committees has heard a lot of testimony to that effect, there's also the problem of, it seems from our perspective, that so many things exist which ought to be done first structurally before one finds one's self in the corner of having to do a mandate. A mandate almost looks like the easy first step. The four points that I've outlined, it seems to me, ought to be preconditions and their failure ought to be preconditions to a discussion of whether or not one would mandate a market for insurance.

I would say one other thing as regards to the community rating question that was posed before and, in fact, it ties into this. In this city I think the notion of community rating is thrown around with almost total abandon, as if that is somehow the Valhalla that would solve things. Community rating, for all kinds of reasons, has not looked like pure community rating since, perhaps, 1950. It is hard to sustain community rating in a competitive market.

Moreover, the most important thing, I think, that ought to be understood, and is clearly not understood one wit by the drafters of either Senate bill 768 or House bill 1845, is the notion that community rating is in a specific geographic locale, a community. When it starts to move to a State or to a region, it has profoundly perverse effects in terms of cost-containment strategy. When you start to make Syracuse bear the costs of profligate practice in New York City, there is no incentive in that city at all to maintain discipline in the provider system. Its notion of the nexus between dollars spent here and discipline here, is totally blown when you expand the notion of community rate beyond a geographic locale.

Chairman ROCKEFELLER. OK. Thank you. Bob.

Mr. HUNTER. I'm not opposed to a mandate, but I'm concerned about the impacts. If you don't have some control on costs and coverage, what are you mandating? Obviously, that's an important thing, particularly when you see some of the small group prices and some of the preexisting condition exclusions that are now in small group contracts and even total exclusion of some employees by some insurers in small group contracts. If you start mandating things like, who's going to mandate the delivery system so that employers can comply?

Mr. HAVENS. Senator?

Chairman ROCKEFELLER. Bob, I was engaged in conversation and totally missed your answer.

Mr. HUNTER. OK.

Chairman ROCKEFELLER. Could you do it again?

Mr. HUNTER. Sure.

Chairman ROCKEFELLER. I apologize.

Mr. HUNTER. I said I am not opposed to a mandate, but I'm worried about the costs and the coverage considerations. If you're mandating to an employer—say small employers—and say "you must buy this" and the price is out of sight or the insurer will exclude certain employees—like the letter my group received which is attached to my testimony—getting letters saying that we're going to exclude specific employees or specific coverages of preexisting conditions for new employees and we're charging, you know, monumental rates. Those kinds of things are going to cause great dislocations if you don't also control price, coverage, and availability where you mandate purchase.

Chairman ROCKEFELLER. Barney—and I'll come to you, Sam, right away—one point. Bob made an earlier point and I forgot, I think it was in the context of your own family you pay about $12,000 for insurance?

Mr. HUNTER. Right. I'm going to negotiate that. That's what they're proposing.

Chairman ROCKEFELLER. Oh, I see, all right. Mr. Monson had indicated that he couldn't and then you came back and you said, well, in fact, I had that checked. There are the $350 in one plan, $750 on another. I assume that has to do with copayment and I'm wondering, in fact, what——

Mr. TRESNOWSKI. Deductible.

Chairman ROCKEFELLER. Deductible. I'm wondering what, in fact, the cost to him as a whole would be? And I don't know his circumstances.

Mr. TRESNOWSKI. The $350 deductible plan is $181 a month. The $750 deductible is $138 a month. They're now considering even a third option with a $2,000 deductible, which would be about $110 a month.

Chairman ROCKEFELLER. OK. Thank you. Sam.

Mr. HAVENS. Just two comments, Mr. Chairman. One on community rating and the issue of the community rating and the experience rating and so forth. I think it would be instructive to look at the experience of the HMO industry. Clearly, and more recently because of competitive pressures, the HMO industry is beginning to move from what could be considered community rating toward something that includes health status. And it is a problem, I think, for HMO's as well, but I think the history of HMO's and how they have rated their product would be helpful for the Commission to look at.

Second, on the issue of mandated coverage, speaking for GHAA, the board of GHAA agrees in concept with mandated coverages but has some difficulties with a number of the specifics that are in current recommended legislation, because of our concern of the inability of these health care systems called HMO's to operate. But we are on record already with those concerns. Thank you.

Chairman **Rockefeller**. Thank you. I'm going to just ask one final question, sort of at Barney and Carl, but anybody else who wants to comment is fine too, and then we'll all go eat. By and large the business community has been fairly universally opposed to any new taxes to fund any additional health programs and I think we all assume that there are going to have to be. Catastrophic taught us whatever lesson it taught us, but it can't ultimately deter us from long-term care of the uninsured and this kind of thing.

On the other hand, today the business groups have called for Medicaid expansion and buy-in programs, which will cost the Federal Government a little bit over $21 billion each year and the State governments over $15 billion each year. You've asked for a 100-percent deductibility of health insurance premiums for the self-employed uninsured, which will cost $1.3 billion in lost tax revenues for fiscal 1990. Now, there may be a business consensus on these point, but we have to find a way to pay for them. And I'm just wondering what your suggestions are if taxes are out?

Mr. **Tresnowski**. Well, let me say, one of the phenomenon, and you know this better than anybody, currently is that we're looking for revenue neutral solutions to complex social problems. The point I made a few moments ago about seeking to finance a mandate through some pluralism in financing means that everybody's going to have to put up.

The employer, indeed, is going to have to pay. I think the employee should be required to pay either part of the premium or through some cocost sharing or whatever. I think providers using the vehicle of insurance should be willing to concede discounts, deferentials, those sorts of things, and a lot more that we could talk about, but I think Government's going to have to. You know, you say, how do we do it without raising revenues? I'm not an expert on how you raise Government revenues. I know the word tax. But I don't think Government can turn its back on these situations.

It seems inconsistent, to me, for the State government to continue to legislate State benefit mandates and at the same time complain about the fact that we've got a growing problem of access to care. So, you know, I just don't think that they can walk away from them.

Medicaid, you know, what—two-fifths of the poor people in this country are covered by Medicaid. That means three-fifths are not. We've really got to address the Medicaid question. And I'm not sure that that means a lot of new taxes. I don't know. But I just don't think that anybody could sit anywhere and say that the Government doesn't have a responsibility. I know that's not responsive to your no revenue question.

Chairman ROCKEFELLER. No; I understand what you're getting at, Barney. Bob, you were talking about the San Francisco earthquake and I'm just wondering in my own mind, I guess. The House is voting today on *x* billions of dollars for relief and there's almost kind of a comparable thing here. Californians have led the charge on saying no more taxes and then by God they did a lot about it, proposition 13 and elsewhere.

And I don't know when the Senate's going to vote on this, but I'm kind of interested in, you know, what is California going to do about some of its own limitations on its ability to—willingness to tax its people or change their views as it comes roaring instinctively to the Federal Government for, you know, $2, $3, $5, $7 billion? I mean, it was one thing back at the St. Helen's with Warren Magnuson because there was lots of money then. There's no money anymore. And I just—you know, they want to come and get a lot from the Congress, but what are they going to do? What are they going to do about some of their Jarvis-Curtis-Ganns instincts out there, if that's what his name was? Carl.

Dr. SCHRAMM. Senator, I'd make two specific responses to your question about where's the money going to come from. The first is just a historical observation and it comes in the vein of "we gave at the office." I don't think you can array a panel of 100 experts in health care financing and find one who hasn't said and doesn't believe that the process of cost shifting, using our companies and Blue Cross plans, has had the providers shift an undue burden into our customers' pockets. That's the whole phenomena of what cost shift is about.

When providers don't have an adequate income stream from the publicly insured beneficiary community, they jigger prices. They know it. It's in their literature. It's in their seminars. We appreciate it fulsomely.

So, we have been historically paying more than the due share and that is an implicit taxing mechanism. It is an implicit taxing phenomena that's been going on with the encouragement of the Federal Congress since 1972, when the title 19 program specifically was the first to go. Basically the States were encouraged to operate discipline in terms of their payout without establishing some scheme to make the provider community operate more efficiently, either toward the public beneficiaries or to all users of the system. So, that's my historical comment.

The second part is, as regard to our proposal, we would argue with the estimate. Our biggest estimate of what the title 19 recommitment would be, is about $10 billion, not $21 billion. I don't know where that figure comes from.

As regards to the buy-in. We believe that is totally revenue neutral. Which is to say, as you encourage more people to use Medicaid at the margin as they go into employment, the reinsurance effect, if you will, will more than offset the additional cost to the States of guaranteeing to people on the way out of poverty to buy-in ability. No question, there would, in fact, be tax expenditures for the restoration of 100-percent deduction to the self-employed.

As regards to these new revenues, our historic position for well over a decade would be that the Congress would appropriately turn to sin taxes or excise taxes, principally on tobacco.

Chairman **Rockefeller**. Which brings in what? If you do tobacco and the various spirits, can you get much over $10 billion?

Dr. **Schramm**. One of your copanelists, Congressman Stark, from time to time talks illustratively of the $15 a pack cigarette tax.

Chairman **Rockefeller**. $15? Yes, well, that would do so with more——

Dr. **Schramm**. Yes; I guess the answer is, it depends on how ready you are to punish the tobacco industry.

Chairman **Rockefeller**. Yes. OK. Sam.

Mr. **Havens**. Yes, Mr. Chairman. Just one comment on that, not on the tax side as much as on the cost side. Once again, I urge all that the Commission can do to support organized systems. I think only through organized systems will we have enough money to be able to afford health care for anyone. And there are clearly things beginning to happen where these systems are moving across the country, enrolling more people. But we must avoid the barriers to their continued rapid development. Thank you.

Mr. **Irons**. Mr. Chairman, this is not my association's position. But in discussion today in anticipation of this question, looking at the agents perspective involved, the agents do very sincerely try to expand health insurance coverage. Obviously, there's a sale involved. But there is in dealing with the employer, the small employer, the understanding of what that does for morale, the synergistic effect within the company.

If the companies were to design products for the poor and near-poor and adjust commission rates, if you will, the agents could be involved conceptually in a pro bono attitude, as the lawyers do with the poor who need representation. This is the kind of a contribution I think the agent ranks could make.

One thing that I would counsel very strongly to you is that the idea of imposing a tax upon business we believe, very strongly from our personal involvement—and now I speak primarily with the small businesses of America—we believe very strongly that that will be counterproductive.

That that will not—section 89, the discussion of that in the early ranks, that immediately brought to the minds of many employers very simply the solution was, we're going to get rid of the coverage because we cannot handle the administrative costs. There are many small American businesses today that with the Pacific Rim situation and the European in 1992, the pressure is tremendously there. And so, the idea of taxing the businesses to provide this coverage, we think would be counterproductive.

However, we think that the companies and the agents can be involved in working with the Congress. We also believe very strongly that nationalizing this and making it a Federal program will end up in a disaster; 10 years from now it will be just the reverse of what we're trying to accomplish.

The picture painted by Mr. Hunter, I think, is totally incorrect. It's not falling apart. What's happening? We're going through tremendous transformation in what health care is available, in the ability of Americans to get the health care, to understand health care, to be encouraged to utilize health care. This is a new world. It's not a collapsing situation. It's an emerging situation. And we in the private sector, the agents and the companies, truly do want to participate to have a synergistic relationship with the Government.

Chairman **Rockefeller**. On that optimistic note, gentlemen, I thank you all, and this hearing is adjourned.

[Whereupon, at 1:50 p.m., the hearing was adjourned.]

APPENDIX

NATIONAL MULTIPLE SCLEROSIS SOCIETY
205 EAST 42 STREET, NEW YORK, NY 10017-5706 (212) 986-3240 FAX (212) 986-7981

Chairman
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F. Lee H. Wendell

Vice Chairman
Mrs. Frederic E. Camp

President and C.E.O.
Thor Hanson
VADM, USN (Ret.)

July 7, 1989

The Honorable Doug Walgren
United States House of Representatives
Washington, D.C. 20515

Dear Mr. Walgren:

Per your request for specific instances of insurance denial based on a pre-existing condition, enclosed are three cases.

These examples come from Virginia, California and Pennsylvania. While some are "better" anecdotes, I can get you examples from nearly anywhere in the country.

Let me reiterate our support for your legislation H.R.2649. If there is anything we can do to assist in its passage, please feel free to call on us.

Sincerely,

Michael B. Losow

Michael B. Losow
Manager
Government Affairs

MBL/drg

Enclosures

The National Multiple Sclerosis Society is proud to be a source of information about multiple sclerosis. Our comments are based on professional advice, published experience and expert opinion, but do not represent therapeutic recommendation or prescription. For specific information and advice, consult your personal physician.

June. 26, 1989

TO WHOM THIS MAY CONCERN:-

I, Pauline Couch, have been informed that the 24th of February 1990 all medical and dental and vision care will cease under my current group policy with Pittsburgh Home Savings + Loan Association. I also was informed that I could pick up a single policy but would have to pay almost twice as much and get less benefits.

With my current financial situation I will find it impossible to carry any insurance and being I get above the amount Pennsylvania Welfare allows, they will not help. Medicare through Social Security Disability will not take affect until I am on Total disability for two years. I only started to receive total disability in August of 1988.

I have contacted other insurance companies and was told because I have a pre-existing illness (multiple Sclerosis) they would not be able to cover me or if they did it would be the same as with the company I worked for with high premiums and less benefits.

I already pay $113.00 per month for dental and vision and medical but must pay the first $600.00 which I find very difficult because of other financial commitments.

Any help you can provide will be gratefully appreciated.

Sincerely,

Pauline Bacik
319 MATHEWS AVENUE
PITTSBURGH, PA. 15210

HOME TELEPHONE NUMBER

412-481-9331

JUNE 21, 1989

MR. MICHAEL LOSOW
MANAGER OF GOVERNMENT AFFAIRS
NATIONAL MULTIPLE SCLEROSIS SOCIETY
205 E. 42ND STREET
NEW YORK, NY 1007-5706

DEAR MR. LOSOW:

IN 1986, I WAS BEING TREATED BY THE DOCTORS AT A HOSPITAL I WORKED FOR AS A FLOOR NURSE FOR A KNEE PROBLEM. AFTER EXTENSIVE TESTING WITH NOTHING RESOLVED, MY HUSBAND CHANGED JOBS AND THINKING THIS WAS A KNEE PROBLEM, WE MOVED TO A DIFFERENT AREA. AT THAT TIME I VISITED A NEW DOCTOR, WHO WITHIN TWO VISITS HAD DIAGNOSES ME WITH MS.

I HAD MAINTAINED MY INSURANCE UNTIL SEPTEMBER OF 1986 AT WHICH TIME I CONVERTED TO COBRA. MY COBRA WAS CLOSE TO RUNNING OUT, AND I HAD BEEN TRYING TO FIND INSURANCE. I HAD MANAGED TO GET A PART TIME JOB AT AN INSURANCE COMPANY, WITH NO BENEFITS. I WROTE TO THE DEPARTMENT OF INSURANCE TO FIND OUT WHICH INSURANCE COMPANIES WOULD INSURE A PRE-EXISTING CONDITION, AND THERE WERE NONE UNLESS YOU GOT IN ON AN OPEN ENROLLMENT WHICH IS ALMOST IMPOSSIBLE. THE INSURANCE COMPANY I WORKED FOR CHECKED WITH THEIR UNDERWRITER AND THEY WOULD NOT ISSUE INSURANCE BECAUSE OF THE MS. I ALSO WAS REJECTED BY BLUE SHIELD BECAUSE OF THE MS. I DID CONVERT MY COBRA AT THE COST OF $2,054 FOR SIX MONTHS. WHEN MY INSURANCE CAME UP FOR RENEWAL, EVEN THOUGH I HAD NO CLAIMS, AETNA RAISED THE COST TO WELL OVER $5,000 PER YEAR. THEY STATED "IT WAS THEIR EXPERIENCE THAT ANYONE WHO CONVERTED WAS A HIGH RISK."

AT THAT TIME, THE JOB MY HUSBAND HAD TAKEN WAS NOT WORKING OUT AND THE CONCERN OF NO MEDICAL COVERAGE WAS OVERWHELMING. HE IS NOW STAYING AT A JOB HE IS REALLY NOT HAPPY IN AS INSURANCE IS SUCH A FACTOR.

I HAVE BEEN LUCKY, BECAUSE THE INSURANCE COMPANY I WENT TO WORK FOR HAS A POLICY THAT AFTER ONE YEAR OF PART TIME WE ARE ELIGIBLE FOR BENEFITS. NEEDLESS TO SAY IT IS A VERY GOOD FEELING. WE ARE STILL LIMITED, BECAUSE MY HUSBAND IS THE MAJOR BREAD WINNER AND I AM OVER 50, SO JOBS FOR ME ARE NOT AS AVAILABLE, AND IF HE CHANGES AND WE HAVE TO MOVE, THEN AGAIN I AM LOOKING AT NO INSURANCE. I HOPE TO WORK UNTIL I AM 53 &1/2, (LONGER IF I FEEL GOOD) BUT

CONT...

IF NOT AT THAT AGE, I COULD TAKE THE INSURANCE THROUGH COBRA AND THAT WOULD CARRY ME UNTIL 55 AND ELIGIBLE FOR MEDICARE.

ALL THIS IS BASED ON MY CONTINUED ABILITY TO WORK, AND I KNOW FROM TALKING TO OTHER MS CONTACTS, HOW VERY LUCKY I AM. MS USUALLY STRIKES YOUNG PEOPLE WHO HAVE TO DEAL A LIFE TIME WITH THIS. WE REALLY DO NEED SOME TYPE OF COVERAGE FOR MS AND SO DO OTHER PEOPLE WITH OTHER DISEASES. THE FACT THAT THIS IS SUCH A "WELL ORIENTATED SOCIETY", THAT THEY WOULD RATHER FORCE PEOPLE TO BECOME DEPENDENT ON THE STATE AND DESTROY A FAMILY'S ABILITY TO TAKE CARE OF THEMSELVES, THEN PASS A BILL FOR INSURANCE THAT WOULD ALLOW THOSE WHO CAN STILL BE A VIABLE PART OF SOCIETY AT WHAT EVER LEVEL THEY CAN ACHIEVE, IS SAD.

I REALIZE THAT THIS LETTER IS WAY TO LONG, AND AS I SAID, I AM VERY LUCKY THAT I WAS 50 INSTEAD OF 24 WHEN I WAS DIAGNOSED WITH MS, BUT MY CONCERN IS SO GREAT, I WISH I COULD PUT INTO WORDS THE UTTER TERROR ONE FEELS WHEN YOU ARE NO LONGER ABLE TO BE INDEPENDANT, OR TO CONTINUE TO BE A HELP MATE TO YOUR PARTNER, OR TO SEE THE DREAMS OF ALMOST 30 YEARS OF HARD WORK GO UP IN ONE WORD, DISEASE.

I WISH YOU ALL THE BEST WITH THE NATIONAL LEGISLATION YOU ARE PLANNING TO INTRODUCE. THIS IS REALLY NEEDED SO THAT PEOPLE CAN CONTINUE TO LIVE & FUNCTION AND NOT BECOME A BURDEN, INSPITE OF DISEASE.

SINCERELY,

Jean Naber

JEAN NABER
281 W. 20TH ST.
UPLAND, CA
91786

BLUE SHIELD
of California

CPIC
CALIFORNIA PHYSICIANS INSURANCE CORPORATION

BSC INDIVIDUAL UNDERWRITING DEPARTMENT
P.O. BOX 3008; LODI, CA 95241-1912

July 13, 1988

Regina J Naber

281 West 20 Th St
Upland CA 91786

RE: Regina J Naber
ID# 551483117
QCN 819406489

Dear Ms. Naber:

This letter is to explain the reason your application for health coverage was declined. Our decision was based on information provided on your application.

It was indicated that You have multiple sclerosis. We regret that we are unable to approve coverage for applicants with this condition.

Thank you for considering Blue Shield for health coverage.

Sincerely,

Carol Allen

Carol Allen
Associate Underwriter

TIME INSURANCE COMPANY
515 West Wells
P. O. Box 624
Milwaukee, WI 53201
Telephone: (414) 271-3011

TIME

April 5, 1989

Mr. David Lusby

RECEIVED APR 17 1989

11512

Dear Mr. Lusby:

Development Team, Inc.
Case 74076-7

We have completed our underwriting review on the application submitted for Myra Shneider under the above subject case.

On the basis of Ms. Shneider's diagnosis of Multiple Sclerosis in 1981, we are unable to consider coverage.

Please advise the business of our action by forwarding a copy of this letter.

We regret our inability to be of assistance at this time.

Cordially,

Ronald J. Schaber, Jr., Underwriter
Employee Benefits--Underwriting

RJS/xF4

COMMONWEALTH OF VIRGINIA

STEVEN T. FOSTER
COMMISSIONER OF INSURANCE

Box 1157
RICHMOND, VA 23209
TELEPHONE: (804) 786-3741

STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

May 19, 1989

RECEIVED MAY 22 1989

Mr. Harry L. Hall
2111 Wilson Boulevard, Suite 405
Arlington, VA 22201

Re: Our File No. 89 138 009

Dear Mr. Hall:

Commissioner of Insurance, Steven T. Foster, asked that I acknowledge receipt of your letter dated May 11, 1989. We are concurrently contacting the insurance company, and as soon as they respond to our request, we will be better able to discuss the matter with you.

In the meantime, should you have any questions, please do not hesitate to contact us.

Sincerely,

Pamela Gillespie ln

Pamela P. Gillespie, CIE
Senior Consumer Services Representative
Life and Health Division
Telephone Number (804) 786-6867

PPG:ln

The Development Team, Inc.
2111 Wilson Boulevard, Suite 405
Arlington, Virginia 22201
(703) 525-2997

Harry L. Hall, President

May 11, 1989

Insurance Commissioner
Insurance Commission, Commonwealth of Virginia
1220 Bank Street
Jefferson Building
Richmond, VA 23219

Dear Commissioner:

Enclosed is a copy of a letter from Time Insurance Company to the agent for our company policy, Mr. David Lusby at Insurit Inc., 10560 Main Street, Suite 315, Fairfax, VA 22030.

The Development Team, Inc., a not-for-profit corporation in the state of Virginia, currently with four full-time employees, has been denied coverage in its group health insurance plan for one of its employees (who is just running out of her COBRA with a prior employer) solely on the basis of the fact that she was diagnosed with multiple sclerosis in 1981.

Is this denial of coverage legal in the state of Virginia?

Are there any provisions of law related to insurance or other factors which would permit The Development Team, Inc. to obtain group insurance for all members of its staff, including the person who was diagnosed with multiple sclerosis in 1981?

What advice do you have for us?

Cordially yours,

Harry L. Hall

Harry L. Hall

cc: Myra A. Shneider

October 10, 1989

Rep. Doug Walgren
U.S. House of Representative's
Room 2241 Rayburn Bldg.
Washington D.C. 20515

ATTN: Glenda Booth

Dear Sir:

I would like to thank you for introducing HR 2649 Health Incsurance Equity Act.

My mother was diagnosed with cancer this past January. By June my father's employer tryed to change insurance companys. They were rejected by the first company for too many potential patients with pre-existing conditions. Finally, the company was picked up by Community Mutual-Blue Cross effective June 1st.

My mother passed away June 28th and to this day I am still working weekly with Blue Cross on claims that are rejected in part or whole due to pre-existing conditions.

Certainly this country's health insurance system, if left unimproved, could cause countless precious lives to be lost and inflate the deficit tremendously. You should be applauded for any improvement in our health care system now and in the future.

Thank you,

Aug. 30, 1989

Dear Mr. Walgren,

Tonight, in the Orphan Disease Update (a newsletter published by the National Organization for Rare Diseases), I was delighted to read about the Health Insurance Equity Act. I am the mother of an 8 year old daughter. Becky was born with a rare birth defect which left her with only 10% of her small intestine. As a result, she requires daily intravenous feedings. The intravenous feedings unfortunately, have caused liver disease. Her medical costs are very high, but I have been fortunate in that I am an RN. and am able to care for her at home, which has helped keep costs down. She is a normal child in most other aspects. She attends 2nd grade at a public school, and recently helped the local hospital raise $120,000 by serving as the local spokeschild for the Children's Miracle Network Telethon.

Before Becky's birth, my husband and I ~~were~~ recieved our health insurance through an HMO. We recieved this plan through my husbands place of employment. When my husband left that place of employment, we began paying for a family plan. At that time, my husband, who is a veterinarian, was self-employed. After Becky was born in September 1981, our coverage continued without probems until 2 year ago. At that time, we were paying approximatel $200.00 / month plus a $500.00 ~~premium~~ deductibles. Since that time, our monthly premiums have continued to increase about every six months. Last month, we recieved another increase notice As of October 1, we will be required to pay $801.00/month plus the $500.00 deductible to continue our coverage. We have spent this last month trying to find an alternative. All that is available is the HIRSP plan and MA (Katie Beckett Program). Neither one is really ideal for us. HIRSP has a $500,000 lifetime maximum. Becky's supplies alone cost $13,000/month, and she is facing major surgery in the near future We have Katie Beckett as a supplemental coverage now, but if at anytime she fails to meet one of the 7 requirements of eligibility, she will be dropped from this program, and have no coverage. Also to our disadvantage is the fact that my husband and I are both professionals. No one looks at our expenses, just at my husbands income. When I calle the insurance company to complain about this latest increase, it was suggested that I go back to work to pay for Becky's medica insurance. As I pointed out to the woman I spoke to, I would need to pay a nurse $10 to $12/hr. to come to my home to care for Becky. Since our insurance does not cover nursing care at home, my entire check woul go to pay the nurse!

We have been told many times over the last month that the only solution to the insurance problem is legislation that would control HMO's and private insurance companies, and prevent them from pricing persons with a chronic illness out of their plans. We weren't sure how to go about getting such legislation introduced, so we are thrilled with the work you are doing, and are willing to help in this effort in any way possible. ¶ I realize this letter is quite lengthy, but we have become increasingly frustrated over the past 2 years, and it is such a relief to find someone who seems concerned with the problems we are experiencing. Please send me more information on the Health Insurance Equity Act, and thank you very much for your work in this area.

Sincerely,

Valerie Schreiner

Mrs. Valerie Schreiner
203 Brookfield Dr.
Stratford, WI. 54484
715-687-4551

OCT 02 1989

Sept 26th 1989.

Dear Congressman Walgren

I have just read your pre-existing medical program. and I am very interested in working for the cause

Federal Health Ins. Equity act HR2649 is greatly needed There are millions of people in the United States who are unable to get health Ins.

Right now (for the third time) there is a bill (S.B 6) on Gov. Deukmejian's desk. It is a bill for pooled-risk health Ins. There are 5 million people in the state of Calif. who are unable to get health Ins.

I got involved after my husband received a kidney transplant and our health Ins went to $5,000." a month making it impossible to afford.

IV health Insurance

I will be more than happy to do my part to help in any was possible –

Sincerely;

Gloria Ross

4843 Gaynor Ave

Encino, California

91436

phone #

818-981-1098

MEMO

TO: Health Access - potential witness - file

FROM: Gordon Bonnyman

DATE: December 28, 1988

RE: Elaine Forrester
410 Columbus Trail Court
Madison, TN 37115
(Ph: 865-8947)

Elaine Forrester called me on December 22, 1988. She is a white, 27-year-old office worker. She has a 4-year-old daughter, a six-year-old stepdaughter, and a husband, Mark Forrester, who is a minister. His income is $27,000 a year, which now comprises the family's total income.

Elaine underwent bone marrow transplant surgery for leukemia some months ago. Although she had good insurance through her employer, the procedure still has left the family with about $5,000 in medical bills which they do not know how to pay.

She was calling because of concern that she was denied an opportunity to return to work due to her medical history and its effect on her employer's experience-rated health insurance premiums. She believes, but cannot prove, that that is the reason why she was not allowed to return to work after being off for several months as a result of the transplant surgery. She always had excellent performance ratings for the several years that she worked for the company before her illness. She is now being told by the employer that her position has been eliminated, but that she may be considered if a new position comes open after the first of the year.

Apparently, under the terms of the group insurance policy, if she does not return to work in the current calendar year, she would be treated as a new hire and her pre-existing condition, i.e.leukemia, would be excluded from coverage under the health policy. It would therefore not affect the employer's experience rating or premiums.

She is particularly bitter about the irony of being considered a "new" insured whose "pre-existing" conditions can be excluded, because the same Blue Cross policy that the company has now, paid for much of her coverage during the past months when she has been paying the premiums herself to continue her coverage under the COBRA continuation-of-benefits law, the protection of which is about to run out.

Her husband has health insurance, and the children have coverage as his dependents, but unless she can find a job that will afford her group coverage, they will be unable to afford insurance for the family member most in need of health coverage.

She is upset about the whole health cost and health insurance problem and is willing to speak to public officials or journalists regarding her experience.

MEMO

TO: Medical Horror Story file

FROM: Gordon Bonnyman

DATE: May 16, 1988

RE: Debbie Manier (pronounced "Maynor"), Rt. 2, 114 Timber Trail, Hendersonville, TN 37075. Ph: (615) 824-9481.

They have chronically ill child, Jayme, born premature (d/o/b 10/21/86) who has incurred $160,000 in medical bills. Permanently mentally handicapped. Cerebral palsy, plus rare genetic problem (Beckwith Weidemann syndrome), large tongue, intestines coming out, large at birth. Little known about it. Not expected to live through infancy, cannot hold head up, difficulty feeding. Wasn't expected to live a year.

Insurance had $1 million cap. They have paid pediatrician and prescriptions themselves (about $10,000 total at least) to try to stretch insurance. Only $500 in savings now.

Husband works at Mr. Transmission as mechanic making $40,000 a year. She is a homemaker. They had Jefferson Pilot Life group policy that employer paid entirely. Insurance first went up from $170/month for family to $340/month last November, now going to $600 effective June 1. Mr. Transmission will drop it and go to another plan, but it won't cover their daughter. Last year the Insurance Company said they collected $103,000 in premiums from franchises across the country and paid out $198,000 in claims. Most franchises moved to another company when they made the first jump last fall. Even if the family paid $7,000 for the next 6 months they would face the loss of insurance at the end of that period because the rates would just probably go up again. The underwriter explained to them, "It is my honest opinion that they are trying to get rid of Jayme."

They have about $40,000 equity in house, $600/month mortgage. They are worried about losing their home. "It's bad enough to watch her suffer but to think we'll lose everything..."

Jayme is on an apnea monitor, heart monitor, takes Rx 7 times a day. Therapy class costs $80/wk. She already has had 3 brain surgeries, V.P. shunt.

Vanderbilt calls all the time, even though she has insurance. The first time she had to have brain surgery the insurance coverage was 85% until they had paid a $1,000 deductible, then 100% above that. They preregistered and were told by Vanderbilt to bring $500 with them. They started dunning her within 3 weeks for the $500 balance. Collections hounded them, were nasty. This was before insurance had paid. They have had to buy a new car since the old car couldn't make it back and forth to the medical care.

Vanderbilt has been nasty. She says that half the stuff on the bill they didn't do. For example, they were supposed to do 12 chest percussions a day when they never did more than three. She says she had to go make sure Jayme got her medications because Vanderbilt wouldn't do it. She stayed with Jayme practically all the time to be sure she was cared for. They charged $600 for five days of seizure medication: a month's supply costs $100 at a regular pharmacy.

They have considered divorce, her husband has considered quitting his job. They are concerned about their son: "We can't stop his life because his sister is sick."

6/6/88 - I spoke to Debbie again. She sent in premiums for the State Insurance Pool coverage effective 5/2/88, so they will have to wait for 6 months from then. Mr. Transmission moved to another group coverage effective 6/1/88, but sent in premiums to the old company for the Maniers only. They're doubtful that this will work, since it isn't "group coverage." It was a last-ditch attempt.

To
Don [illegible]
[illegible]

Canada

506 Parkview Drive
Pittsburgh, Pa. 15243
May 9, 1989

Dear Representative McHugh,

I am enclosing an article from the NORD newsletter which is self-explanatory. I would also like to explain my interest in the subject. Our daughter has a rare disease. She is living in Toronto, Canada, where her medical care is excellent, and her costs are within reason for a young working woman. She is unable to work, at times, and the type of work she can do is limited, however, she does manage to find employers who understand her plight and are willing to hire her anyway. The reason she went to Canada is that my husband's family lives there, and she has the advantages of the Canadian medical and insurance plans.

At this time, given the status of American medical plans and insurance plans, she is not insurable here, and cannot reside in the U.S. even though she is an American citizen. Neither we, nor she, can afford the hospital stays which are so vital to her survival. She is fortunate to be able to reside in Canada, but we are aware of many more U.S. citizens who are not able to make that move. Is this fair?

I urge you to push hard for adquate health insurance for this type of person, and to develop better government funding for the coordination of and the research into the cure of rare diseases.

Sincerely,

Ann Bregman
Ann Bregman

ORPHAN DISEASE UPDATE

VOL. VII Ed.3 SPRING 1989

National Organization for Rare Disorders • NORD • P. O. Box 8923 • New Fairfield, CT 06812

...out of the darkness, into the light...

NORD is a particiapant in the Combined Federal Campaign, #0551 in the CFC Brochure.

National Commission on Orphan Diseases Submits Report to Congress

The report of the **National Commission on Orphan Diseases** was submitted to Congress during April 1989. The Commission's Chairman, Dr. Jess Thoene (who is also NORD's President) presented the report to Rep. Henry Waxman (D-Ca) and Senator Edward Kennedy (D-Mass) who are Chairmen of the congressional health subcommittees that mandated the Commission through an amendment to the Orphan Drug Act.

For two years the Commission studied the multitude of problems related to rare disease research, dissemination of information, transfer of technology and the impact of orphan diseases on the twenty million Americans whose lives are touched by these illnesses. The Commission's findings will hopefully lay the groundwork for the future as Congress begins to consider and hopefully act upon the recommendations contained in the report.

Some of the Commission's major findings include:

- During 1987 the federal government spent $1.3 billion on rare disease research; the pharmaceutical industry spent $51.6 million; and foundations spent $41.6 million.
- **Of the $1.3 billion spent by the U. S. government on rare disease research, over half was spent on approximately 200 rare forms of cancer. This left only $640 million for the remaining 4,800 orphan diseases.**
- Biomedical researchers working on both rare and common diseases agree that it is harder to get funding for rare disease research than for research on a prevalent disease.
- Researchers feel that the lack of funds for research is the single greatest barrier to discovery of treatments for rare disorders.
- The Commission found that many of the barriers to progress on research and treatments for rare diseases are caused by both lack of funding and a lack of coordination of existing resources.
- 47% of researchers reported that it is difficult to find a sufficient number of patients to participate in a research project on a rare disease. On the other hand, 76% of rare disease patients reported that it is difficult to obtain information about research projects that they might want to participate in.

In a survey of practicing physicians conducted by the Commission in conjunction with the American Medical Association, the Commission found:

- 42% of doctors say they need, but are unable to find printed information to give to their rare disease patients concerning their illness.
- 48.6% of doctors believe there is an adequate number of support groups for their rare disease patients in their community; 44.5% believe there are enough voluntary support groups on the national level.
- 39% of these physicians had used an investigational drug or device for at least one of their patients; of these, 92% said they would do so again. Of those physicians who had never used an experimental treatment, 72% said they would not consider using them.
- 91.5% of physicians feel that limiting legal liability for doctors using experimental drugs would be an appropriate way of increasing research on rare diseases.
- The most frequently used sources of information doctors use for diagnosing and treating rare disease patients are pharmaceutical companies (46%), the Centers for Disease Control (41%), and the National Institutes of Health (39%).

The surveys of people with rare disorders and national voluntary health agencies were reported in the last issue of **Orphan Disease Update** (Vol. 7, Ed 2, Winter, 1988). These surveys documentated the financial devastation caused by these illnesses and the lengthy time lapse between onset of symptoms and a proper diagnosis (31% took between one and five years to receive a proper diagnosis, and 15% went undiagnosed six or more years; 45% said their illness caused extreme financial hardship and 42% reported that their disorder prevents them from working or attending school). The Commission also found:

- 9% of people with orphan diseases have no health insurance, and an additional 7% have insurance that does not cover their primary medical condition. The Commission concluded that this number is likely to grow as more restrictive underwriting standards are adopted and new diagnostic techniques become available (i.e., genetic tests).
- The Commission urged Congress to assure that every person in the U.S. should have access to health insur-

Continued on page 4

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New Orphan Drugs Approved ....Page 6

Survey *Continued from page 1*

ance for themselves and their families at reasonable cost.

- The Commission recommended that the health insurance industry should reimburse patients with rare diseases for appropriate and necessary care such as physical and speech therapy, dental care (when it is related to the primary medical condition), genetic testing and counseling, over-the-counter products such as bandages, investigational drugs, marketed drugs that are not labeled for a rare disease, and medical foods for inborn errors of metabolism.

A survey of 106 foundations that fund biomedical research indicated that:

- Only 12 foundations funded rare disease research grants: These 12 foundations devoted only 1.3% of their medical research budget to rare disease grants.

The survey of voluntary health agencies indicated that:

- 48% of voluntary health agencies for orphan diseases fund biomedical research grants on rare disorders.
- One-half of the voluntary health agencies surveyed estimated that the cost of medical care for patients with the disease they represent ranges from $9,500 to $115.00 per year.

Examination of the **Orphan Drug Act** and the role of the FDA in orphan product development concluded:

- Congress has not adequately funded the FDA Orphan Products Development Program. $12 million was authorized to be spent in 1988, but only $7 million was appropriated, with not less than $5 million to be spent on grants to scientists developing new treatments for rare diseases. **This is the only program within the federal government that is specifically devoted to rare disease research.**
- Since the Orphan Drug Act was implemented in 1983, 257 orphan products have been designated by the FDA, and 33 of those products are approved for marketing. Progress has been slow, and more incentives may be needed to spur the development of new orphan products that are not related to cancer nor AIDS.
- Concerns about liability may deter corporations and physicians from conducting research and developing new products for rare diseases.
- The FDA's New Drug Approval process must be expedited without unduly compromising safety.
- Medical foods and orphan devices should be added to the Orphan Drug Act because they are not being adequately developed.
- Pharmaceutical manufacturers reported that the primary incentive of the Orphan Drug Act is the seven years exclusive marketing provisions for a designated orphan drug.

The Commission concluded that **rare disease research and product development are largely uncoordinated and underfunded; information is lacking and poorly disseminated; the financial burden of an orphan disease can reduce a family to poverty. *In short, the needs of patients with orphan diseases are not being adequately met.***

The Commission made numerous recommendations to solve some of the problems outlined in the report. Some of the recommendations will require legislation, some will require regulatory changes, and some will require a massive educational effort so that policy makers and the public will begin to understand the unique problems associated with orphan diseases. A major recommendation provides for a central office for orphan diseases within the federal government to coordinate and monitor public and private efforts for rare disorders.

If you wish to obtain a copy of the entire report contact: **National Commission on Orphan Diseases**, Park Building, Room 1-20, 5600 Fishers Lane, Rockville, Maryland 20857.

It is vitally important to remember that the Commission's recommendations will not be adopted by Congress automatically, especially during a time of fiscal restraint. Members of Congress will read the report if they are asked to do so by their constituents, and they will act upon it only if they feel that voters in their home state think it is important. *It* is up to us, people with orphan diseases, our families and friends, to focus the attention of policymakers on the plight of people with orphan diseases and urge them to seek solutions. Let's work hard **together** to ensure that the Commission's recommendations are implemented.

HELP PERPETUATE NORD's WORK - REMEMBER NORD IN YOUR WILL

You can give hope to 20 million Americans by extending your support of NORD's programs beyond your lifetime. Whether your legacy is large or small, you can support our programs of education, service, and research by remembering NORD in your will.

To make a bequest of cash or other property to NORD, your Will (or supplemental codicil, if you do not wish to write a new will), should state:

"I give and bequeath to the National Organization for Rare Disorders Inc., a not-for-profit corporation, organized under the laws of the state of New York, and having its principal office at 100 Route 37, New Fairfield, CT 06812, the sum of $(__________) or (__________) per cent of the rest, residue, and remainder of my estate to be used for general purposes of the Organization."

A bequest to NORD is fully deductible for estate tax purposes. In addition, remembering NORD in your Will is an important and personal way of providing hope to people with orphan diseases for generations to come. You may wish to learn about other gift opportunities by consulting your attorney, accountant and/or tax estate planning specialist.

SEP 12 [illegible]

506 Parkview Drive
Pittsburgh, Pa, 15243
September 5, 1989

Dear Doug,

Mort and I are very grateful for your action on the matter of insuring people with pre-existing conditions. Patti, our daughter is directly affected by this, as you know, as are so many others. I have sent copies of the enclosed article to friends all over the country, asking them to contact their legislators and to continue sending the article to their friends requesting that they do likewise. This has been the first positive sign of action that we have seen, and we are most appreciative.

Best wishes to Carmella and to her continued efforts on behalf of families suffering with severe illnesses.

Sincerely,

Ann

Ann Bregman

Please write
or call
Heinz, & Specter
Thanks.
Ann & Mat

ORPHAN DISEASE UPDATE©
VOL. VIII Ed.1 National Organization for Rare Disorders SUMMER 1989
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* * BULLETIN * *

REPRESENTATIVE DOUG WALGREN INTRODUCES HEALTH INSURANCE EQUITY ACT

On June 14, 1989 Congressman Doug Walgren (D-PA) introduced the **Federal Health Insurance Equity Act** (H.R.2649) which, if enacted, will prohibit health insurance companies from excluding, terminating or otherwise limiting an individual from coverage based on a "preexisting" health condition.

Rep. Walgren noted that the federal Office of Technology Assessment estimates that 20% of those applying for commercial health insurance face preexisting conditions resulting in either increased premiums for health insurance, or exclusion for coverage altogether. He also noted the **National Commission on Orphan Diseases** reported that 16% of those with rare diseases were unable to acquire adequate health insurance.

Mr. Walgren feels that, "By excluding or in some way limiting coverage for people with preexisting conditions, commercial insurers cover only the healthy, leaving those who are ill without the ability to use insurance to spread their risks or medical costs beyond themselves." In short, the bill aims to spread risks across a large number of policyholders. "Every individual should be able to join a large enough group that they are put on an equal footing with regard to costs that any other insured person enjoys," said Mr. Walgren.

The bill would prohibit health insurance companies from excluding or limiting benefits for people with preexisting conditions; prohibit setting premium rates on the basis of a patient's claims, or the claims of small groups; it would permit health insurance companies to have minimum enrollment periods or waiting periods *only* if they are uniformly applied to *all* policyholders; states would be required to establish an office to investigate violations of the Act; insurers would have a civil penalty of $100 per day, per enrollee, for each day they do not comply with the standards; insurers found not in compliance with the law would be liable for damages, including all health care costs incurred by a patient; the Secretary of Health and Human Services would publish standards for insurers to provide minimum services at reasonable cost.

The **Health Insurance Equity Act** will not pass Congress unless there is a ground swell of support from consumers. To obtain more information about the proposed law, write: Rep. Doug Walgren, U.S. House of Representatives, Room 2241, Rayburn House Office Building, Washington, D.C. 20515. To find out whether your Congressman and Senators support or oppose this legislation, contact them at either their state office or their Washington, D.C. office. Senators can be reached at U.S. Senate, Washington, D.C. 20510; Representatives can be reached at U.S. House of Representatives, Washington, D.C. 20515.

Rep. & Mrs. Walgren Receive Awards

Shown above are Congressman Doug Walgren, his wife, Mrs. Carmala Walgren, and their family. (See story below)

1989 ANNUAL TRIBUTE BANQUET AND NATIONAL CONFERENCE

NORD's 1989 Annual Conference convened in Arlington, Virginia on May 21 through 23, 1989. The Annual Tribute Banquet, which honors outstanding leaders and corporations who have made significant contributions to the wel-

continued on page 3

Thank Doug
if you have
the opportunity

uncement ..Page 2
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arc
Association for Retarded Citizens • WASHINGTON COUNTY
4450 S.W. 184th • P.O. Box 5778 • Aloha, OR 97006-5778
(503) 649-6110 / 649-7184

September 18, 1989

Representative Doug Walgren
c/o Glenda Booth
United States House of Representatives
2241 Rayburn House Office Building
Washington, D.C. 20510

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EXECUTIVE DIRECTOR
Cary R. Schaye

Dear Representative Walgren,

I am enclosing some information from families who have been denied health insurance coverage and/or charged an excessive premium because a family member with disabilities represents a health risk.

For the Wyffels family, I have enclosed a written statement from Beverly Wyffels, copies of letters from her son's physicians, and a copy of one health insurance company's denial. Mrs. Wyffels has additional material, and can be contacted by writing her at 7750 N.W. Pike, Yamhill, Oregon 97140.

I am also enclosing notes from a conversation I had with Wendy Bass about her experience of being denied coverage or charged excessive premiums from numerous insurance companies. She is willing to be contacted directly, by calling 503-640-9240, or by writing to 1221 N.E. Birchaire Lane, Hillsboro, Oregon 97124.

The ARC enthusiastically supports H.R. 2649, and recognizes an acute need for this legislation. I hope to send you additional testimony soon; please contact me if you need any other information.

Sincerely,

Sara Fischer
Advocacy Director

cc: Allan Bergman
Les AuCoin

A United Way Agency

To whom it may concern,

The family of Michael Wyffels JR. has been Refused insurance twice. Although doctors sent letters Stating Michaels condition caused no further medical costs than other normal children, P.A.CC. excepted Michael excluding his disabilities We had a $500.00 deductible, that was never met. Therefore Michael cost them nothing. Enclosed are two letters sent to the insurance companies when we applied, I

[redacted] [redacted]

PREPARED BY
DATE

hope they are helpful.

We have applied for S.S.I. But there are 4 months out of the year for positive that we will not qualify. Maybe more. At this point in time we are still in the process to find out if we will qualify at all. If Michael were to have something serious happen to him which required hospitaliz Surgery or other major medical we would have to declare bankrup

I hope this letter has been helpful

Sincerely

thePrincipal Financial Group

Principal Mutual Life
Insurance Company
711 High Street
Des Moines, Iowa 50309

AUG 21 1989

August 18, 1989

BAILEY NURSERIES INC
ATTN BRIAN BOWMAN
9855 NW PIKE RD
YANHILL OR 97148

Acct No: N35520-1
Dependents Of
Michael Wyffels
Medical Coverage

007

Dear Brian Bowman

The person listed above has applied for coverage under a Plan with our company.

Subject to all provisions of the above Plan, the coverage is approved for Beverly, spouse of Michael Wyffels and children Samuel and Emily effective September 1, 1989.

However, after our review of the application, we must decline to issue the coverage to Michael Jr, child of Micheal Wyffels. Our decision is due to the medical information provided.

Sincerely

(Miss) Debbie McDowell
Group Medical Underwriting
(515) 247-6163

PHYSICIANS'
MEDICAL
CENTER, P.C.
Physicians and Surgeons

420 E. FIFTH STREET • McMINNVILLE, OREGON 97128 • TELEPHONE 472-6161

July 27, 1989

RE: Michael E. Wyffels

To Whom It May Concern:

Michael Wyffels is a young child now 8 years old who is followed in our clinic with the diagnosis of cerebral palsy and microcephaly. This has been present since birth and is not a progressive illness. He has no other serious medical problems and is seen for normal childhood illnesses.

If I can be of any further help to you concerning Michael's medical condition, please do not hesitate to call.

Sincerely,

Susan Katz MD

Susan Katz, M. D.

SK:mh

ARNELLE SURFACE
Administrator

P.E. TURNER, M.D.
Internal Medicine

S.E. KATZ, M.D.
Pediatrician

H.R. HOOVER, M.D.
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Family Practice

M.D. STEPHENS, M.D.
Internal Medicine

PHYSICIANS'
MEDICAL
CENTER, P.C.
Physicians and Surgeons

420 E. FIFTH STREET • McMINNVILLE, OREGON 97128 • TELEPHONE 472-616

Mailed out
5/31/85

May 24, 1985

Bankers Life Insurance Co.
% Beverly Wyffels
P.O. Box 403
Yamhill, Oregon 97148

RE: Michael E. Wyffels
DOB: 4-21-81

To Whom It May Concern:

I understand the the Wyffels family is seeking medical insurance coverage. Michael Wyffels is a patient of mine that I have followed since six months of age. He is known to have microcephaly, developmental delay and mild ataxic cerebral palsy. Michael is ambulatory and attending school and receiving special education. He has had no difficulty with epilepsy or other complicating medical problem. His general health has been good. He has had no hospitalizations and it is not anticipated that his current developmental disturbances are going to create significant long term medical complications.

If you need further information to qualify this family for insurance coverage, please feel free to contact me.

Sincerely,

David W. Willis, M.D.

DWW:mh

M.L. WYNN, M.D.
General Surgeon

S.F. KATZ, M.D.
Pediatrician

G.K. RESCHLY, M.D.
Family Practice

J.T. WOO, M.D.
Internal Medicine

C. HUSTON, M.D.
Family Practice

B.H. [illegible], M.D.
Pediatrician

[illegible]
Administrator

M.W. OLSON, M.D.
Family Practice

M.D. STEPHENS, M.D.
Internal Medicine

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Association for Retarded Citizens • **WASHINGTON COUNTY**
4450 S.W. 184th • P.O. Box 5778 • Aloha, OR 97006-5778
(503) 649-6110/649-7184

September 11, 1989

From a conversation with Wendy Bass about her experience with getting health insurance coverage:

Ms. Bass has two children, ages 4 and 11, who are developmentally disabled, with a diagnosis of "encephalopathy of unknown origin." They each have a seizure disorder which is well under control. When Ms. Bass needed to look for new health insurance coverage, she got letters from her children's pediatrician stating that neither child represented any kind of a health risk; while severely developmentally delayed, both children are in good health.

Mr. and Ms. Bass are financially able to purchase health insurance privately, but have been rejected by every insurance company they have contacted. Several of the companies said that they would insure Mr. and Ms. Bass and their child without disabilities, but not the two children with disabilities.

With the help of an insurance agent, Ms. Bass eventually found a company in Kansas which would insure the whole family with a great many exclusions, including the kids' annual visit to a neurologist. The family did not feel comfortable with an insurance company so far away, or with all of the exclusions.

The family was rejected by Blue Cross, by the health insurance arms of Prudential and State Farm, and by numerous other companies, including PACC, a large Oregon PPO. For over a year they have been purchasing health coverage from Mr. Bass' former employer, but cannot do that indefinitely.

Ms. Bass is willing to supply more information if need be; she can be contact at:

Wendy Bass
1221 N.E. Birchaire Lane
Hillsboro, Oregon 97124

(503) 640-9240

June 30, 1989

JUL [illegible] 1989

Paul R. Billings, M.D.,Phd., Director
Clinic for Inherited Diseases
Harvard Medical School
New England Deaconess Hospital
Boston, Mass. 92215

Dear Dr. Billings;

Re: Insurance Problems
American Porphyria Foundation
newsleter summer of 1989

I have been totally denied either health or life insurance for ten years or more. I have AIP which was diagnosed and treated at NIH in 1974-75. Applications must be answered truthfully to be effective and to do so is to deny yourself coverage. The conclusions by underwriters at insurance companies when confronted with genetic problems leads one to believe they do not intent to make an effort to understand. It is much simpler to catagorize and deny health or life insurance to the applicant. This is not just a problem of genetic discrimination. All insurance companies insure the healthy. They do not insure persons with questionable health. Thanks to computors, social secutiry ID numbers, we are able to have companies like MIB, Boston. They keep records on the health of many individuals and for a small fee will give insurance companies damning ambiguous reports such as "Disorder of Blood, not specifically coded; reported present at time of inquiry or application".

This insidious system of discrimination against persons in this country is so widespread changing it can probably only be done at the highest levels of government, but changing it to a system of government health care would provide us with inferior care at all levels.

I sincerely hope you find answers and find a way to implement them.

Best regards:

Marvin Mathia
403 Queensboro Place
Yukon, Oklahoma 73099

cc: Desiree Dodson
American Porphyria Foundation
P.O.Box 11163
Montgomery, Al. 36111
a: June 23 letter to Desiree Dodson

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out of the darkness, into the light

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Myasthenia Gravis Foundation
Narcolepsy Network
National Addison's Disease Foundation
National Association for Sickle Cell Disease, Inc.
National Congenital Port Wine Stain Foundation
National Foundation for Ectodermal Dysplasias
National Foundation for Peroneal Muscular Atrophy
National Gaucher Foundation, Inc.
National Head Injury Foundation
National Marfan Foundation
National Mucopolysaccharidoses Society, Inc.
National Multiple Sclerosis Society
National Tay-Sachs & Allied Diseases Association
National Vitiligo Foundation, Inc.
Osteogenesis Imperfecta Foundation
Paget's Disease Foundation, Inc.
Parkinson's Disease Foundation, Inc.
Polycystic Kidney Research Foundation
Prader-Willi Syndrome Association
Reflex Sympathetic Dystrophy Syndrome Association
Retinitis Pigmentosa Foundation Fighting Blindness
Scleroderma Info Exchange, Inc.
Scleroderma Federation, Inc.
Sjogren's Syndrome Foundation, Inc.
Tourette Syndrome Association, Inc.
United Leukodystrophy Foundation, Inc.
United Parkinson Foundation
Williams Syndrome Association
Wilson's Disease Association

July 25, 1989

Glenda Booth
c/o Rep. Doug Walgren
U. S. House of Representatives
2241 Rayburn Bldg.
Washington, DC 20515

Dear Glenda:

Enclosed are a few more horror stories, mostly from Sjogren's Syndrome patients. The Sjogren's Syndrome Foundation put a notice in their newsletter and that's why we're primarily getting letters from Sjogren's patients. In a few weeks we'll have other diseases.

Best regards.

Abbey

Abbey S. Meyers
Executive Director

ASM:aa

Enclosures

Dedicated to Helping People with Orphan Diseases

Barbara Moosberg
Rt. 1 Box 392
Kaufman, Tx 75142

Jesse Thaen, M.D.

I'm writing in reference to the article in "The Moisture Seekers" newsletter, June 1989, "Have You Been Denied Medical Insurance?"

Until August 1988, I had medical coverage through a group plan where I worked. The company folded and I was left without insurance. I then tried through several companies to get coverage and was denied each time, because I have Sjogren's Syndrome.

I am not financially able to get professional help without some kind of medical coverage. Hopefully things will change.

Thank you
Barbara Moosberg

Dear Dr. Horne:

I am a patient at Mayo Clinic being observed for Amyloidosis. I do not use the word treated because they apparently think there is nothing that can be done for the disease. So they just call me in for tests every few weeks & observe the results. However, certain things that I am doing at home on my own seem to be helping as my last tests were better than previously & the only answer can be certain vitamins & supplements I am taking. I would be willing to be a research guinea pig if I could have help with my monthly Dr. bills for which I have no insurance & not old enough for Medicare

Contact me if we can get together on something

I have had the disease for 2 yrs as of July 1989. Feeling good now. About only problem is high cholesterol for which I'm on a test program also.

Lorraine Pitzer
R 2 Box 238
St. Charles MN
55972

Note: Amyloidosis is a serious disease, mostly progressive and untreatable. I believe the mayor of Pittsburgh or Philadelphia died from this recently.

P.O. Box 5351
Melville, New York 11747

EQUICOR

Date: 4.4.89

John + Waneta Mehaffey
804 E. Pennsylvania Ave
Urbana, IL 61801

RE: Declination
Applicant: John Mehaffey
Social Security #
For Dependent: Waneta

Dear Mr. Mehaffey

In accordance with your request regarding the declination of your application for group health coverage under the State of Illinois Basic Health Plan we have written to:

Dr. Phillip Johnson c/o Carle Clinic
602 W. University Ave
Urbana, IL 61801

We suggest that you contact Dr. Johnson at the above address for the reason for such declination.

If you wish to further appeal this declinatin you may request in writing to the department of Central Management Services at: Division of Group Insurance, Att: Director of CMS, 600 Stratton Bldg., Springfield, ILL 62706, that a final review be performed. Upon receipt of this request, a review committee may choose to investigate the declination. The committee may request additional written materials and/or schedule a meeting with you. The committee will make a recommendation to the Director of Central Management Services whose decision shall be final and binding.

Sincerely,

Medical Underwriting
(516) 845-3315

July 19, 1989

Jesse Thoene, M.D.
% NORD, P.O. Box 8923
New Fairfield CT 06812

RE: Refusal of Insurance Coverage

Dear Dr. Thoene:

My case is a little unusual, but I thought it might be interesting to you. I work for the City of Urbana - my husband works for the University of Illinois. Rather he is retired from the University of Illinois. We both have Carle Care with our individual companies. As I have reached the age of considering retirement, I decided to convert over to my husband's policy as the coverage was a little better, and according to my understanding, if he precedes me in death, I would automatically be accepted on his policy even though I had not been on it before. With this in mind, I applied to Carle Care to transfer my coverage from City of Urbana to the University of Illinois. They have refused to allow this.

I reappealed, and then ask they send me the medical evidence substantiating their refusal. They sent it to Dr. Johnson.

[illegible]

Doctor Johnson has said I have a mild case of Primary Sjogrens, and with the use of REFRESH eye drops, OCEAN nose spray, SALIVART mouth moistener, PREMERIN vaginal cream, plus Advil, Calcium, and Vitamins, I have improved my condition quite a lot. The medications that my former doctor had me on were things that were drying me out even more, and I was miserable. I just thank God I found a doctor that was knowledgeable about Sjogrens!

Dr. Johnson told me they had refused me as I had had several attacks of Sjogren's Syndrome within one year of application - which proves they know nothing about the disease. Secondly they said I may reapply in 3 years - and one thing they were concerned about the first time was my age - and in 3 years I will not be any younger! I am writing to Equicor again explaining these items, but I am sure it will do no good. Their coverage is not as good now as it was in the past - they have added many more co-pays, such as $10 for every Doctor's visit, and I am not sure that this would make up for the prescription coverage or not. I only have two prescriptions that I fill only a few times a year. The other is Naphcon A for allergies affecting ey

I am enclosing the documentation to show this progression of events.

Sincerely,

Waneta Mehaffey

Waneta Mehaffey
804 E. Pennsylvania
Urbana IL 61801

CMS ILLINOIS DEPARTMENT OF
CENTRAL MANAGEMENT SERVICES

HEALTH CERTIFICATE

ILLINOIS STATE EMPLOYEES
GROUP HEALTH INSURANCE PROGRAM

Dependent enrolled in Medicare Part: A X B ___ A&B ___

One of these forms must be completed for each individual.

This form submitted to: [✓ add dependent] ___ upgrade dependent health coverage ___ other - specify ______

1. Name of Member John Mehaffey	2. Member's Soc. Sec. No. [illegible]-10-7771
3. Work Location retired	
4. Employing Agency or Retirement System SURS	5. Carrier Name Carle Care

TO BE COMPLETED FOR DEPENDENTS BEING ENROLLED:

6. Name of Dependent WANETA E. MEHAFFEY	7. Relationship to Member 24 WIFE	8. Dependent's Occupation LIBRARY CLERK III
9. Date of Birth - Dependent [illegible], 1923	10. Sex of Dependent ___ Male [✓ Female]	11. Height 5 ft. 4½ inches 12. Weight 184 lbs.

13. Are you covered by any other group health insurance plan?	[✓ Yes] No	If yes, give the name, address and group policy number of the other carrier. CarleCare 6-224-0CC11
14. To the best of your knowledge and belief, are you now in good health and entirely free from any mental or physical impairments or deformities?	Yes No	If no, give details diagnosed Sjogrens Syndrome no medication. dry eyes, and mouth. no other problems from testing (over)
15. Do you have or have you had any of the following: rupture; hemorrhoids (piles); removal of growth; gall bladder or bowel trouble; rectal bleeding; stomach or duodenal ulcers?	[✓ Yes] No	If yes, give details has gall bladder removed in 1977
16. Do you have or have you had any of the following: heart disease; stroke; artery or vein problem; rheumatic fever; high blood pressure or hypertension?	Yes [✓ No]	If yes, give details. If high blood pressure, list last pressure reading.
17. Have you been advised to have a surgical operation for any cause which has not been performed?	Yes [✓ No]	If yes, give details (dates, reason, and name and address of attending physician(s)). Tonsillectomy 19[illegible]; 2 Caesareans - 1944 + 1949 DR. GARRETT. Goiter removal, 1967(?). (over)
18. Have you undergone any surgical operation?	[✓ Yes] No	If yes, give details (dates, reason, and name and address of attending physician(s)). See above - sorry!
19. Do you have or have you had any of the following: diabetes; kidney infection or disease; prostate or urinary trouble; cancer; asthma; allergies or breathing problems?	[✓ Yes] No	If yes, give dates and details. Allergies - (Dr Hayes, Carle Clinic, [illegible])
20. Do you have or have you had mental or nervous disorder; been treated for alcoholism or drug abuse?	Yes [✓ No]	If yes, give dates and details.
21. To the best of your knowledge and belief have you had female disorders or are you pregnant?	[✓ Yes] No	If yes, give dates and details. had female disorder & had a hysterectomy in 1975
22. Have you been absent from work due to a prolonged illness or injury during the past six months?	Yes [✓ No]	If yes, give reason, date(s) and duration of absence.
23. To the best of your knowledge and belief have you had other diseases, illnesses, ailments or operations not mentioned above?	Yes [✓ No]	If yes, give dates and details.

24. Have you visited any: physicians, surgeons, anesthesiologists, radiologists, psychiatrists, registered clinical psychologists, osteopaths, chiropractors, podiatrists or chiropodists during the past five years for other than routine examinations? [✓ Yes] ___ No

If yes, furnish the following information: Dr. Phillip B. Johnson Carle Clinic

Date	Symptoms or Ailment and Treatment	Name of Physician	Address of Physician	Treatment
annually [illegible] 88	Dry eyes, mouth, nose (Sjogrens Syndrome)	Dr. Phillip B. Johnson	Carle Clinic [illegible]	use eye moisturizing ointment & [illegible] chew gum, see dentist regularly. Avoid sugar. [illegible]

It is understood and agreed that to the best of my knowledge and belief the above statements and answers are true and complete and that they are the basis on which Group Insurance requested by me may be issued. It is further understood and agreed that any material misrepresentation or any withholding of material information herein will entitle the appropriate carrier to deny the validity of any insurance granted on the basis of these answers.

As required by the Illinois Information and Privacy Protection Law, you may request and obtain a "Notice of Information Practices" from your Group Insurance Representative or Preparer before you sign this health certificate.

25. Signature of Group Insurance Representative or Preparer [illegible]	26. Signature of Applicant (If for adult dependent, that person must sign form—or, employee for a minor or mentally handicapped dependent.) Waneta E. Mehaffey	27. Date 21 apr '88

The following section will be completed by the Insurance Carrier

___ Approved [✓ Disapproved] ___ Physical Examination Required ___ Further Information Requested ___ Doctor's Statement on Question No. ___ Required

Date of Carrier Approval or Disapproval 6/15/88	Signature of Insurance Carrier Representative

(43)

Upon approval or disapproval, the health carrier or HMO will return this health certificate to the agency group insurance representative or preparer noted below.

Name
STATE UNIVERSITIES RETIREMENT SYSTEM Department
50 GERTY DRIVE
P.O. BOX 2710, STATION A Address
CHAMPAIGN, ILLINOIS 61820 City, State, Zip Code

217-333-3560 SURS

Home 217-367-8161 Telephone
Work 217-361-4057

Doctor took me off medication
I was taking, Take Advil, Calcium
+ vitamin tablets. Thyroid tested OK
this week.

[illegible]

Rectal Fissure, 1970ish Dr Keyes
Gallbladder, 1974 Dr. Ross
Hysterectomy 1975 Dr Wilson
[illegible] + [illegible] Clinic

DR. JOHNSON does
not consider
me a High Risk
Patient.

804 E. Pennsylvania Ave.
Urbana IL 61801
March 16, 1989

EQUICOR, INC.
Medical Underwriting
P.O. Box 5351
Melville NY 11747-0194

Dear Staff:

I am in receipt of the decision of the underwriters in regard to my appeal to change from my Carle Care Insurance issued by the City of Urbana to the Carle Care Insurance issued by the University Retirement System under my husband's policy.

I wish to know exactly what medical evidence submitted lead to the decision to decline my request.

Please submit a written report to me as soon as possible. Please cover all the details. I wish to discuss the report with Dr. Phillip B. Johnson of the Carle Clinic. According to his report to me following my complete physical in March, I am in good condition and I wish to know what evidence you considered for refusal.

I would appreciate an immediate reply to this request.

Sincerely,

Waneta Mehaffey

(S.U.R.S., 50 Gerty Dr., P.O. Box 2710, Station A, Champaign IL 61820
ATT: Julia Jones)

May 10, 1989

Dr. Phillip Johnson
℅ Carle Clinic
602 W. University Ave
Urbana IL 61801

Dear Dr. Johnson:

I have been advised by EQUICOR, Inc. that they have sent you a letter concerning the declination of my application for group insurance coverage under the State of Illinois Basic Health Plan as a dependent on my husband's policy.

I had written to them asking what grounds they declined to issue me the insurance (as I already have Carle Care under the City Plan and just wanted to change carriers). I stated I had just had a physical and that my doctor had not indicated that I had any reason to be concerned.

I need to decide whether to further appeal this declination and so I need your input in the matter. Will you please reveiw the papers they sent you, send me a copy along with a response to the various reasons for the declination? If you wish to see me, I would be glad to come in for a consultation in this matter.

They have advised me that I may appeal to the Central Mgmt. Serv. at Springfield and they will require additional written materials and perhaps a meeting with me. I need to know more before making this decision which will probably take more of your time as well as mine. The decision of the Director of Central Management Services would be deemed final and binding.

According to the reading I have done on Sjogrens Syndrome, the Primary Sjogrens seems to be thought as the milder form of the disorder. As the thyroid is now normal, the lupus level is not too high, and the arthritus is about the same as it has been for several years, I wonder if they can just reject me on being overweight! I'm sure it is more than this, but I would really like to know if I should pursue the matter further and I believe I need your input at this time.

I would appreciate your opinion in this matter as soon as you can find the time to advise me.

Sincerely,

Waneta Mehaffey
804 E. Pennsylvania
Urbana IL 61801

Clinic # 060224

Carle

060224

May 15, 1989

Mrs. Waneta Mehaffey
804 East Pennsylvania
Urbana, IL 61801

Dear Mrs. Mehaffey:

In response to your letter of May 10, I checked your chart and found the note from the Medical Underwriting Division of Equicor, Incorporated. Their note is somewhat cryptic but ends up saying that in a handwritten note that you had "multiple attacks of Sjogren's syndrome within one year of application. She may reapply in three years." They further state that they were required by their medical department to decline the application for group health coverage.

My advice is to discuss with them what they mean by "multiple attacks os Sjogren's syndrome." In February of 1988, my notes indicated that you had dry eyes for over three years and dry mouth for 3-4 years, along with dry nose. You also had some gum trouble and recession of the gums. The duration of these symptoms at least puts the onset farther back than one year from application time but seems to prove that you did have some symptoms during the one year prior to your application, which is probably all they mean by the handwritten note. They may just have a policy against underwriting anybody who has Sjogren's syndrome if they can help it, regardless of whether it is primary or secondary and regardless of its severity. So, I think you should just double check whether the mere fact of having Sjorgen's syndrome makes you ineligible regardless of how mild it might be. If they are bound and determined not to underwrite for anybody with Sjorgen's syndrome, then I think you would have only one recourse and that is to get legal opinions as to what your options are after that.

Sincerely,

Philip B. Johnson, M.D.
td
Typed: May 15, 1989

National Organization for Rare Disorders, Inc.
NORD • P.O. Box 8923 • New Fairfield, CT 06812 • (203) 746-6518 • FAX: (203) 746-6481

out of the darkness, into the light

President:
Jess Thoene, M.D.

Executive Director:
Abbey S. Meyers

Member Organizations:
Acoustic Neuroma Association
American Narcolepsy Association
American Porphyria Foundation
Amyotrophic Lateral Sclerosis Association
Ankylosing Spondylitis Association
Association for Brain Tumor Research
Association for Glycogen Storage Disease
Batten Disease Support & Research Association
Benign Essential Blepharospasm Research Foundation, Inc.
Cornelia de Lange Syndrome Foundation, Inc.
Cystinosis Foundation, Inc.
Dizziness & Balance Disorders Association of America, Inc.
Dysautonomia Foundation, Inc.
Dystonia Medical Research Foundation
Dystrophic Epidermolysis Bullosa Research Assoc. (D.E.B.R.A.)
Ehlers-Danlos National Foundation
Epilepsy Foundation of America
Families of Spinal Muscular Atrophy
Foundation for Ichthyosis & Related Skin Types (F.I.R.S.T.)
Friedreich's Ataxia Group in America
Guillain-Barré Syndrome Support Group International
Hemochromatosis Research Foundation, Inc.
Hereditary Disease Foundation
Histiocytosis-X Association of America, Inc.
Huntington's Disease Society of America, Inc.
Immune Deficiency Foundation
International Craniofacial Foundation
International Joseph Diseases Foundation
International Rett Syndrome Association, Inc.
Interstitial Cystitis Association of America, Inc.
Lowe's Syndrome Association
Lyme Borreliosis Foundation
Malignant Hyperthermia Association of the United States
Meniere's Network (EAR Foundation)
Mucopolysaccharidoses Research Funding Center, Inc.
Myasthenia Gravis Foundation
Narcolepsy Network
National Addison's Disease Foundation
National Association for Sickle Cell Disease, Inc.
National Congenital Port Wine Stain Foundation
National Foundation for Ectodermal Dysplasias
National Foundation for Peroneal Muscular Atrophy
National Gaucher Foundation, Inc.
National Head Injury Foundation
National Marfan Foundation
National Mucopolysaccharidoses Society, Inc.
National Multiple Sclerosis Society
National Tay-Sachs & Allied Diseases Association
National Vitiligo Foundation, Inc.
Osteogenesis Imperfecta Foundation
Paget's Disease Foundation, Inc.
Parkinson's Disease Foundation, Inc.
Polycystic Kidney Research Foundation
Prader-Willi Syndrome Association
Reflex Sympathetic Dystrophy Syndrome Association
Retinitis Pigmentosa Foundation Fighting Blindness
Scleroderma Info Exchange, Inc.
Scleroderma Federation, Inc.
Sjogren's Syndrome Foundation, Inc.
Tourette Syndrome Association, Inc.
United Leukodystrophy Foundation, Inc.
United Parkinson Foundation
Williams Syndrome Association
Wilson's Disease Association

July 18, 1989

Glenda Booth
c/o Rep. Doug Walgren
U. S. House of Representatives
Washington, DC 20515

Dear Glenda:

Concerning our conversation a few days ago, I am sending you a memo we distributed to New York and New Jersey based voluntary health agencies concerning Congressman Florio's committee and hearings on H.R. 2649.

Also enclosed are two letters from patients with Sjogren's Syndrome with documentation concerning denial of health insurance. These cases really illustrate the injustice of the health insurance industry because Sjogren's Syndrome is not life-threatening, and it is no more expensive than arthritis.

Sjogren's is an autoimmune disorder in which the body's natural defenses against disease (antibodies and lymphocytes) mistakenly attack healthy tissue. In this case, mucous secreting glands are destroyed, and affected patients have little or no saliva and tears (dry eyes and dry mouth). They use liquid tears, humidifiers, and they sip water throughout the day. There is no treatment to hault progression of the disorder so they simply go for checkups to guard against complications such as eye infections. There is no reason why these people should have been denied health insurance.

I have asked the Tourette Syndrome Association to write to you. Last year they hired a person with Tourette Syndrome, and their group health insurance company would not cover her. Their appeal asked that the insurer exclude Tourette but at least cover the employee for unrelated conditions such as a broken leg or appendicitis. The insurer still refused even under threat of losing the account. The Tourette Syndrome Association tried to find another insurer but none would cover this employee.

Glenda Booth
July 18, 1989
Page Two

H.R. 2649 (and Congressman Walgren) will be the feature story on the front page of our next newsletter, Orphan Disease Update, which will be mailed at the end of August. By September you should be receiving letters from patients throughout the country, documenting more horror stories.

Please keep me informed and let me know the names of the bill's cosponsors to date.

Best regards,

Abbey

Abbey S. Meyers
Executive Director

ASM:aa

Enclosures

cc: Jess Thoene, M.D.

July 4, 1989

Jesse Thoene, MD
c/o NORD
P.O. Box 8923
New Fairfield, CT 06812

Dr. Jesse Thoene:

I am enclosing health insurance denials to me due to pre-existing condition Sjogrens Syndrome for your information per my reading the Moisture Seekers.

Both Blue Shield & Aetna denied me in writing, however Aetna did eventually insure me with a CMP plan through a different Agent. Also, there were numerous other denials made due to my pre-existing condition but all were by Telephone.

Should you need further information, please don't hesitate to contact me.

Sincerely,

Karen Rouse

(213) 273-7758
403 No Oakhurst Dr.
#105
Beverly Hills CA
90210

Blue Shield
of California

CPIC YOUR LINK TO SECURITY
CALIFORNIA PHYSICIANS' INSURANCE CORPORATION

P.O BOX 3008
LODI, CA 95241-1912

March 12, 1986

Request 1 & 3/26/84

MAR 24 1986

Karen E Rouse
403 No Oaklurst Dr #105
Beverly Hills CA 90210

RE: New Application
ID# 546727565

Dear Ms. Rouse:

Your application requesting health coverage under our Coronet Major Benefits $500.00 deductible plan has been evaluated.

We regret to inform you that your application has been declined. Our decision was based on information indicated on your application.

If you would like more details concerning our decision, please refer to the enclosed "Procedure for Inquiry on Underwriting Decision." This document outlines your rights to the access and disclosure of any confidential information relating to our decision.

The dues submitted with your application will be refunded through your agent under separate cover.

Thank you for considering Blue Shield for health coverage.

Sincerely,

Teresita F. Finones
Underwriter

CC: Agent No. :00800
Progressive Planning Inc
P O Box 1599
Studio City CA 91604

Enclosure

BLUE SHIELD
of California

INDIVIDUAL UNDERWRITING
P O Box 3008, Lodi CA 95241 1912

April 8, 1986

Karen Rouse
403 No. Oakhurst Dr. # 105
Beverly Hills, CA 90210

RE: ID# 546 72 7565

Dear Ms. Rouse:

Your March 25, 1986 letter has been received and we would like to explain the reason for our decision.

It was shown in your health statement that you had been treated for Sjogren's Sydrome from October 1981 to November 1985. Blue Shield declines coverage when there is a history of this condition.

We are sorry we could not respond favorable and do thank you for considering Blue Shield for health coverage.

Sincerely,

Teresita F. Finones
Underwriter

TFF/jr

AHBJ 2 DLHI 86.205 10.04.38

104

Ætna

Personal Financial Security Division
Health Products
151 Farmington Avenue
Hartford, CT 06156
(203) 273-0123

JULY 24, 1986

Kelp

KAREN ROUSE
403 N OAK HURST DR
NO 105
BEVERLY HILLS,CA 91210

IDENTIFICATION NO: CAB0004734 703

DEAR MS. ROUSE

THANK YOU FOR CONSIDERING AETNA FOR YOUR INSURANCE NEEDS.

YOUR PLAN HAS BEEN MODIFIED BECAUSE OF INFORMATION YOU PROVIDED REGARDING SJOGREN'S SYNDROME.

THE PURPOSE OF ANY INSURANCE IS TO COVER UNPREDICTABLE OR UNFORESEEN RISKS. THE PLAN YOU REQUESTED CANNOT BE ISSUED AS APPLIED FOR DUE TO MEDICAL REASONS. THIS MAY OR MAY NOT REQUIRE TREATMENT IN THE FUTURE, HOWEVER, THE POSSIBILITY THAT IT WILL IS GREATER BECAUSE OF THIS HISTORY.

MANY INDIVIDUALS WHO HAVE THIS MEDICAL HISTORY DO VERY WELL. OTHERS CONTINUE TO HAVE MEDICAL CARE OR RELATED SYMPTOMS. SINCE IT IS IMPOSSIBLE FOR US TO TELL WHO WILL DO WELL OR WHO WILL CONTINUE TO HAVE MEDICAL CARE. WE MUST TAKE THE SAME ACTION ON ALL WHO HAVE A SIMILAR HISTORY. THE REASON FOR THE MODIFICATION IS SIMPLY THAT THE INCREASED RISK CANNOT BE SUPPORTED BY THE STANDARD PREMIUM.

THE ENCLOSED UNDERWRITING NOTICE PROVIDES DETAILS AND PROCEDURES ON YOUR RIGHTS TO ACCESS, DISCLOSURE AND CORRECTION OF INFORMATION IN OUR FILE. IF INFORMATION FROM A PHYSICIAN IS REQUESTED, THE ATTENDING PHYSICIAN'S WRITTEN AUTHORIZATION IS REQUIRED TO RELEASE THIS INFORMATION DIRECTLY TO YOU.

WE SUGGEST YOU DISCUSS ANY QUESTIONS WITH YOUR AGENT WHO IS IN A POSITION TO ASSIST YOU.

HEALTH UNDERWRITING DEPARTMENT
AETNA LIFE INSURANCE AND
ANNUITY COMPANY

(24312 A) 6 86

CAT 70542A
PRINTED IN U.S

165 Hemlock Circle
Lawrenceville, GA 30245
July 5, 1989

Dear Dr. Thoene,

I saw a notice in our latest "Moisture Seekers" that said you were looking for information on pre-existing conditions being denied insurance. Enclosed are copies of forms and letters, dating back to 1987, that document my being denied insurance by my (former) employer's insurance company.

If I can be of any further assistance please don't hesitate to contact me. My home phone number is (404) 962-0241.

Best regards,

Pam Brown
President, SSF, Atlanta Chapter

PO Box 20727
Greensboro, NC 27420
919 299 4720

Pilot

Date 6-11-87	Group No 11901	Subject Pamela Brown

This request for contributory benefits has been reviewed. The action taken as indicated :

Barbara Blankenship
Martin Processing Co.
P.O. Box 5[illegible]8
Martinsville, VA 24115

GJ-6069A

☒ **Decline—**
It would please us very much if it could be accepted, however, information available indicates the request for insurance must be declined.

☐ **Delay Period** ____________
Due to information available, coverage cannot be approved at this time. Jefferson-Pilot will be happy to reconsider a new request after the delay period shown has elapsed. If such coverage is desired at that time, have the applicant reapply and furnish current health information. The new request will be given every consideration, however, please do not construe this to mean coverage will be automatically approved at that time.

☐ **Important:** Your State Law requires that a special notice be furnished an employee whose request for coverage results in an adverse underwriting decision. Please be certain the attached notice is furnished the employee immediately.

☐ **Waiver of Named Dependent Election** is in effect for your group. See attached Waiver card.

Thank you for your assistance

Linda Williams - Group Administration 569 age 60 or over have Medical Examiner complete items 26 through 39. A separate blank must be filled out for adult ependent. If dependent application and eligible dependents include children only, complete only Sections 1, 2, 3, A, 4, 5, 21A, B, C, & D, 22a & b 23, 24, & 25 as applicable

Employee Certificate Number
341-42-4985

Name of Applicant—(or Adult Dependent): PAMELA S. BROWN

Home Address: 160 HEMLOCK CIRCLE LAWRENCEVILLE, GA 30245

If applying for dependent coverage, list employee name and date of birth 3 3A

Name of Company to whom Group Policy is issued: MARTIN PROCESSING, INC.

City and State 5

If Adult Dependent: Name of dependent's Employer only. If none write "none" 6

Your Present Occupation: OFFICE MANAGER

Date of Birth: Mo 11 Day 19 Year 49

Height 9 5 ft 4 in

Weight 10 130 lbs

Age 10a 37

THE FOLLOWING QUESTIONS MUST BE ANSWERED — Do not arrange for Medical Exam unless age 60 or over or requested by Pilot Life

		Yes	No
1	Have you ever suffered from or been suspected of having any ailment or disease of		
A	The Brain or Nervous System?	☐	☒
B	The Heart, Lungs, Pleurae or Chest?	☐	☒
C	The Stomach or Intestines, Liver, Kidneys or Bladder?	☐	☒
D	The Skin, Middle Ear, Eyes, Nose or Throat?	☒	☐
2	Have you ever had, been told that you had, or been treated for		
A	High or low blood pressure?	☒	☐
B	Rheumatism, Gout, Syphilis, Cancer, Tumor or Growth?	☒	☐
C	Blood spitting or pain in chest?	☐	☒
D	Diabetes or Tuberculosis?	☐	☒
3	Have you ever had or been treated for an accident or injury?	☐	☒
4	Have you ever undergone or been advised to have an operation?	☒	☐
5	Have you ever been a patient in a hospital, sanitarium or institution?	☒	☐
6	Do you have any disability or deformity, lameness, rupture, or any impairment of sight or hearing?	☐	☒

		Yes	No
17	Have you ever had any abnormalities, disease or disorder of the reproductive organs or breasts, menstruation or pregnancy, whether male or female?	☒	☐
18	Are you aware of any physical defect or complaint not mentioned above?	☒	☐
19	Have you been absent from work due to illness or injury during past six months?	☐	☒
20	Have you consulted a doctor during the past five years for any cause not included in the above answers? (If routine check-up, give details of symptoms and treatment or specify "none", if there were none.)	☐	☐

~~Answer all parts of the following question, No. 21, if benefits include Dental Coverage~~

		Yes	No
~~21~~	~~Have or are you or any of your eligible dependents to be included~~		
~~A~~	~~Now in need of dental treatment of any kind?~~	☐	☐
~~B~~	~~Consulted a dentist during the last 12 months?~~	☐	☐
~~C~~	~~Been advised that dental work was necessary or desirable, or is such dental work contemplated?~~	☐	☐
~~D~~	~~If the answer to C is "yes", has all this work been completed? If "no", give details below~~	☐	☐

GIVE DETAILS REQUIRED BELOW FOR ANY "YES" ANSWER FOR QUESTIONS 11 THROUGH 21C ABOVE AND FOR "NO" ANSWER TO NO. 21.D

QUESTION NO	SYMPTOMS OR AILMENT AND TREATMENT RECEIVED	NAME & ADDRESS OF DOCTOR	DATE	RESULTS	ADDITIONAL TREATMENT NEEDED OR RECOMMENDED
11D, 18	SJOGRENS SYNDROME PENICILLAMINE	DR. GARY MYERSON ATLANTA, GA	4/86		REGULAR CHECKUPS
12 A, B 14, 15, 17	OVARIAN CYSTS; SURGERY	DR. WARD BOURDEAUX ATLANTA, GA	10/81	HYSTERECTOMY	HORMONE REPLACEMENT REGULAR CHECKUPS
12 A	HIGH BLOOD PRESSURE-CAUSED BY PREGNANCY	DR. ROBERT DAVIS ATLANTA	4/78		NONE

22 a I have 0 (number) children eligible as dependents as defined in the group policy and ______ (number) children under 14 days of age

22 b Are all children indicated in answer to question 22 a free of any sickness, impairment or need for medical or surgical treatment?
☐ Yes ☐ No If "No", give name(s) of child(ren) and explain ______

It is understood and agreed that the above statements and answers are true and complete and that they are the basis on which Group Insurance requested by me may be issued. It is further understood and agreed that any material misrepresentation or any withholding of material information herein will entitle Pilot Life Insurance Company to deny the validity of any insurance granted on the basis of these answers.

For purposes of underwriting the insurance requested, I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, employers and group policyholders, contractholders or benefit plan administrators, or other organization, institution or person, that has any records or knowledge of any of the persons proposed for coverage or their health, to give to Pilot Life Insurance Company, any consumer reporting agency acting on its behalf and its reinsurers any such information.

I further request and authorize Pilot Life Insurance Company to furnish all such information obtained by it to my personal physician upon request and hereby waive all privilege to such information.

This authorization shall remain valid for 30 months from the date it is signed. A copy of this authorization shall be considered as effective and valid as the original. I am or my authorized representative is entitled to receive a copy of this authorization.

Signature of employer's authorized representative 26

Signature of applicant—(if health certificate is for adult dependent, that adult dependent must sign this form) 24 Pamela S Brown

Date 25 5/20/97

FOR ☐ EE ☐ EE & DEP ☐ SP ☐ CH ☐ SP & CH

FOR HOME OFFICE USE ONLY. Eff. of Ins. Date ______ By ______

_ Auto
1st of Ins. Mo. Date ______
_ SP.
Field Code No ______

☐ S ADM
☐ REG ADM
☐ SPECIAL

Claims
☐ HO
☐ BO
☐ BROKER

Excess Life Amount To Be Considered

Class	Life

☐ M. Med
☐ H&S
☐ Dental
☐ LTD
☐ VISION
☐ DEP LIFE

☐ Waiver of Named Dep Exclude

☐ Special

PILOT LIFE INSURANCE COMPANY
GROUP ADMINISTRATION DEPARTMENT
GREENSBORO, NC 27420

G 424

(86)

Jefferson-Pilot
Life Insurance Company
PO Box 21008
Greensboro, NC 27420

Jefferso
Pilot

DATE OF MAILING June 11, 1987	FILE NO 11901/18065
APPLICANT'S NAME Pamela Brown	FROM Linda Williams - 569

TO

The following adverse underwriting decision has been made with respect to the insurance transaction we ha been processing for you:

Due to medical information available, your request for coverage has been declined.

You have the right to obtain the specific reasons for this action in writing if not included with this notice. You ar also entitled to know the specific items of information concerning you that support the company's decision an the institutional sources of the information. Written request must be made within 90 business days from the dat of our mailing this notice. Please address any request to the department named above.

Also, at any time upon written request you have the right of access to personal information the company ha recorded about you, incuding institutional sources of the information and the identity of those who hav received the information during the preceding two years or who normally receive it, and the right to copy receive copies of the personal information. The company may make a reasonable charge for furnishing copie

Some medical-record information may be furnished either directly to you or to a qualified medical professiona you designate at the company's option.

Correction, deletion or amendment of recorded personal information about you may be made upon your writte request to the company, but the company is not required to make any changes. If the Company does not agree t any change it will give you its reasons and you may file a concise statement and the reasons for you disagreement which the company will record prominently with its other information about you and will includ with any subsequent disclosure of the information, identifying the disputed information. Either the change o your statement of disagreement will be sent to any insurance support organization that either furnished th original information to or received it from the company and to any one else you designate who may have receive the original information within the preceding two years.

Information about criminal activity, fraud, material misrepresentation or material nondisclosure and informatio collected in connection with a claim or possible claim involving an individual may not have to be disclosed by th company.

BJ-4774

National Organization for Rare Disorders, Inc.
NORD • P.O. Box 8923 • New Fairfield, CT 06812 • (203) 746-6518 • FAX: (203) 746-6481

out of the darkness,
into the light

President:
Jess Thoene, M.D.

Executive Director:
Abbey S. Meyers

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Tourette Syndrome Association, Inc.
United Leukodystrophy Foundation, Inc.
United Parkinson Foundation
Williams Syndrome Association
Wilson's Disease Association

August 2, 1989

Glenda Booth
c/o Rep. Doug Walgren
U. S. House of Representatives
2241 Rayburn Bldg.
Washington, DC 20515

Dear Glenda:

We received an irate phone call from Mr. Harvey Bergolub. I may have sent you a copy of a postcard he wrote because he can't get health insurance for his preexisting condition. He does not want his name used, nor his case identified. Indeed he denies he sent us the postcard.

If you have any reference to this case (a hard to read postcard) please destroy it. I don't know if an intimidation factor played a role in this case, but he has threatened to sue us because he claims he didn't send the postcard (I have the postcard, but you may have a xerox copy).

Sorry for this problem. From now on I'll ask these people to write to you directly rather than deal with an unnamed preexisting condition that may be a mental illness for all we know.

Incidently, United Cerebral Palsy wrote a wonderful review of the H.R. 2649, asking disabled people to contact you. UCP's support is very significant because they reach many thousands of people all over the nation.

Best regards,

Abby

Abbey S. Meyers
Executive Director

ASM:aa

Dedicated to Helping People with Orphan Diseases

September 5, 1989

Dear Congressman Walgren,

My wife and I wish to thank you for introducing H.R. 2649, the Federal Health Insurance Equity Act. I hope this much needed legislation passes.

I have been very fortunate to have reasonably good health, even as a senior citizen. I hope I never have to depend on my insurance, but I carry it "just in case".

The wife of a good friend of mine developed cancer. Her insurance paid for her treatments until the insurance company filed for bankruptcy. Her cancer then became a "pre-existing condition" to other insurance companies, and she was denied coverage. Somehow this just doesn't seem right.

Is there anyone else I should write to and urge passage of H.R. 2649 besides Chairman James Florio?

Sincerely,

Henry S. Allen

Henry S. Allen
929 E. Foothill, Space 195
Upland, CA 91786

August 29, 1989

S.F.

Dear Rep. Doug Walgren,

I am very excited + interested in learning more about the Health Insurance Equity Act. I have been turned down for a health insurance policy at least 12 times. I have Multiple Sclerosis + Bipolar Affective Disorder. I read about it in [illegible].

Unfortunately, health care costs are very expensive + now without insurance my husband's + my pocket are hurting.

Thank you for this wonderful Act. It will be great if it passes.

Sincerely,

Mary Ellen Cobb
909 McKelligon Dr
El Paso, TX 79902

P.S. Please send me more info. on it.

15 September 1989

SEP [illegible]

Representative Doug Walgren
U.S. House of Represenatives, Room 2241
Rayburn House office Building,
Washington, D.C. 20515

Dear Congressman Walgren:

I am writing to thank you for realizing the health problem today with reference to very ill people. My son has cancer. By having the "preexisting" health condition coverage overrided it would be beneficial to very sick people who need the most coverage they could get right away.

While my son was going for treament his employer thought because he had cancer that he would not come back to work so he cancelled his insurance and since the company was notified, and not my son, we did not know that he was terminated from the insurance. It was quite a job getting him back and since his employer just lost a father to cancer he felt bad about the whole situation. Of course it is very sad for these people becasue they have so little to look forward to in the way of hope and to put up with medical prolems from he insurance companies and hospital and doctors fees and make ;you go ino proverty.

I am now trying to get something worked out where airlines can give seats or discounts to sick people to go and get medical treatment when the distance is far away. I know from myself with my son that it has cost us already $5,000 in traveling expenses to and from Buffalo from N.Y.C.

I know that Mrs. Walgren was fighting for telephone service for seriously ill children, why not for people who travel long distances for treatment to save their lives? I am sure tthat airlines could do something to help people, after all they give discounts to students to travel all over, aren't people with medical problems worth more than students who just go home for a visit or travel for vacation?

I want thank you for your time in reading my letter and I want to thank you for realizing the medical problems to sick people in this country. Something has to be done about his situation as it is getting worse as more and more diseases come into being.

My son also has neurofibromatosis and had gotten cancer from this dreadful disease which many people do not know about. It is one of the worst genetic disorders in this country.

Sincerely,

Linda Berger

Linda Berger
259-19 82 Avenue
Floral Park, N.y. 11004

1111 North Gulfstream Avenue, 5-F
Sarasota, Florida 34236
October 3, 1989

Representative Porter Goss
U. S. House of Representatives
509 Cannon House Office Building
Washington, DC 20515

Dear Sir:

I write to urge your co-sponsorship of the HEALTH INSURANCE EQUITY ACT (H.R. 2649).

For several months I have been attempting to obtain individual medical insurance and have learned how very difficult, if not impossible, it is to obtain full, decent and reasonable coverage when one has a medical history of even the most modest proportions.

After waiting three months for my application to be processed by a "Best's A+" company, during which time the insurance company had the use of almost $400 of my money as advance premium, it issued a policy of such limitations and exclusions that even its local agent was appalled. Two major areas of exclusion were not pre-existing conditions per se, but areas where a problem had once occurred (six to nine years ago), and was now resolved.

While I sympathize with those people who can't afford insurance at today's rates, I do think the insurance companies ought to at least offer policies covering pre-existing conditions for those people who might afford appropriate rates for that coverage.

Thank you for your consideration of this problem and any action you can take to resolve it.

I would appreciate your indication as to the possible resolution of this situation.

Very truly yours,

Janet H Leonard

Janet H. Leonard

cc: Rept. Doug Walgren
2241 Rayburn Building
Washington, DC 20515
Att: Glenda Booth

SEP 19 1989

Witt
204 Telegraph Hill Rd
Holmdel NJ 07733

9/13/89

The Honorable Doug WALGREN
US House of Representatives
Room 2241
RAYBURN House Office Bldg
WASHINGTON, D.C. 20515

Dear Sir:

We are very much in support of The Health Insurance Equity Act and would appreciate an update on this proposed act. (H.R. 2649)

Our son was born with Seckel Syndrome and has many Abnormalities. Being a U.S Navy Reserve Recruiter my dependants are covered by Champus. Champus pays 80% of an allowed amount. This is better then no coverage but I am left with large outstanding bills since my son has seizures, on medications, been hospitalized 4 times in his 8 months of age, will need cleft palate surgery, and other complications. We applied for many Champus supplements but were turned down because of his prexisting conditions. Champus has a handicapped program but it allows up to $1000 a month in benefits. Some months he required hospitalization and costs exceed that.

It is really terrible that I'm in the Armed Forces, serving our country, recruiting people to serve and my son is handicapped and I cannot get enough medical coverage to get me out of debt due to the prexisting clause that the insurance companies have in this country.

We hope for our sake and others, that this bill will be enacted.

Marcel Joy Witt

R. Allen Bolt
1502 Wynona
Enid, Oklahoma 73703

July 7, 1989

The Honorable Doug Walgren
Attn: Glenda Booth
2241 Rayburn Bldg.
United States House of Representatives
Washington, D.C. 20515

The Honorable Doug Walgren:

In reference to your legislation that would require insurance companies to accept pre-existing medical conditions, the following is a recap of our experience and the problems we have encountered because there has not been any legislation as such.

In 1978, due to a terminal kidney disease of one of my sons, I almost lost the opportunity to make a job change because of the pre-existing condition. It was only after negotiation that the company agreed to pay all the medical expenses the first year. Of course the base salary was also adjusted in light of this compensation.

In 1986 the company filed bankruptcy and I could not get medical insurance. Since this was forseen, my wife was able to get a job and for the year prior to the cancellation we carried two family hospitalization policies.

In 1988 another job change was made. We were able to continue my wife's hospitalization policy after termination and have just recently completed the year waiting period for my hospitalization policy to pickup on the pre-existing condition. The cost alone on both policies for the past year has been $398.00 per month.

I feel we have been very fortunate to have had things work out as they have, but I am sure that there are many people less fortunate that could not have managed the expense that we incurred or suffered the anguish of having a terminally ill child with no insurance.

Good luck with your legislation.

Sincerely,

R. Allen Bolt

Paul H. Van Wert, A.I.A.
30 Briarhill Drive
Williamsville, NY 14221
August 17, 1989

Honorable Doug Walgren
US House of Representatives
Room 2241
Rayburn Building
Washington, DC 20515

Attention: Glenda Booth

Dear Congressman Walgren:

I would like to congratulate you on sponsoring the Federal Health Insurance Equity Act (HR2649).

I strongly support your efforts and am conveying this to my local representatives.

Very truly yours,

Paul H. Van Wert, A.I.A.

PHV/ajb

August 16, 1989

Rep. Doug Walgren
U.S. House of Representatives
Room 2241
Rayburn Bldg.
Washington D.C. 20515
Attn: Glenda Booth

Congress Walgren:

Just a note to thank you for proposing the Federal Health Insurance Equity Act H.R. 2649.

So much is yet to be done for the health insurance field. Many people that at least are earning a decent living cannot begin to pay the astronomical medical bills caused by the diseases that are not necessarily life threatening but draining in physical being and dollars.

Please send more information about your proposed law.

Thank you.

Sincerely,

Shirley

Shirley Bilbruck
Route 1 Box 215
Calhoun, MO 65323

August 17, 1989

Dear Cong. Walgren:

Your bill, HR 2649, is a masterpiece of concern for our people of all ages.

At last someone has become overtly aware of the health limitations foisted upon us citizens et al and is making an effort to correct the situation.

Thank you and bless you for your consideration

Sincerely
Dr George Kudler
Helen M. Kudler (re Geo)

P.S. I would appreciate more detailed information about the HR 2649 bill.

Thank you

August 22, 1989

AUG 25 1989

Congressman Doug Walgren
U.S. House of Representative's
Room 2241
Rayburn Building
Washington, D.C. 20515
Att: Glenda Booth

Dear Congressman Walgren:

Recently through the publication called "Awareness" it was brought to my attention that you introduced the Health Insurance Equity Act. I have a child with Ehlers Danlos, and although health insurance has not been a prohibiting factor for us, I realize that the insurance companies do restrict and prohibit coverage to many people.

My family is in support of this concept and wish you well in your efforts to convince the industry that in the long run it will be a benefit to all who wish to be insured against this or any other illness. The life insurance companies also should be introduced to the idea that people such as my daughter deserve the right to be insured as much as anyone else. At one time I had to do battle with the family's life insurance carrier because they wanted to waive her like insurance. This meant we had to get Doctors and such to write letters and document her health records in order to get a 6 year old child life insurance. Her condition (thank God) is not life threatening therefore we felt there was no reason for the argument, but the fact that we went through this ordeal was enough to realize that the laws do not consider the people with conditions such as her.

Again thank you for your support.

Sincerely,

Lynne Merritt

Mrs. Lynne Merritt

5429 Gladewright Dr.
Centreville, VA 22020
Tel. 703/830-5912

Aug 21, 1989

Thanks for introducing the Federal Health Insurance Equity Act. Too many of us with "orphan diseases" are denied much needed hospital and medical insurance. I would like to know more about it. (H.R. 2649)

Rose M. Le Bar

MRS P LEBAR
15601 KENNEBEC
SOUTHGATE MI 48195

McMANUS MOVING & STORAGE, INC.
P.O. Box 91390, Pasadena, California 91109-1390
309 South Raymond Avenue, Pasadena, California 91105
(213) 681-8151 • (818) 796-1151

October 13, 1989

Rep. Doug Walgren
U.S. House of Representative's
Room 2241 Rayburn Bldg.
Washington, DC 20515

ATTN: Glenda Booth

Dear Ms. Booth:

I am writting on behalf of my son Richard. Richard now 3 yrs. of age was born with a Genetic disease caled Ectodermal Dysplasias. Which in terms means he was born with no sweat glands. In the last couple of months I have tryed to inquire about health Ins. and have been denied. How can a person be denied of such a thing? Where do they expect us to go? I have been to County services for help and have been denied.

I dont understand if a person is willing to pay monthly payments of up to 300.00 per month for individual health insurance why are they being denied? For the first year of his life as well as the pregnancy I had no insurance, I have been paying out every month for the last few years now.

I hope that in the future we will see some kind of benifit to the people that have the same kind of problems as I have experienced resolved.

Thank you for taking the time to listen to my problems, I'm sure you have heard them all.

Thank You

Mrs. Theresa C. Herrera

ALLIED
Agent for Allied Van Lines®

MEMO

TO: The Jonathan Harley ("John") Young file

FROM: Gordon Bonnyman

DATE: October 19, 1988

RE: Medical access horror story

Tommy Young, age 30, and Pamela Young, age 33, are the parents of John Young, age 12. They also have three other children, girls ages 6, 7 and 10. Their address is Rt. 6, Box 50, Dickson, Tennessee 37055. Phone (615) 446-9725.

Both parents work at the Union Station Hotel in Nashville (phone 726-1001). Tommy is head of the maintenance department at the hotel and makes $20,000 a year. Pam is in charge of housekeeping and makes $15,000 a year. Tommy is a native of Knoxville, and the family moved back to Tennessee three years ago from Muncie, Indiana.

The family has been without health insurance for several months, since Union Station Hotel dropped their employee insurance benefits in an effort to cut the hotel's losses and stay afloat.

Last Saturday, October 15, the couple took their son John to the Vanderbilt University Medical Center emergency room for treatment of two badly infected insect bites. Although they live an hour away from Vanderbilt, they brought him into Nashville for treatment because there is no public hospital in Dickson County.

John is at an age where he is extremely modest, and does not like anyone to see him undressed. He had been limping around for several days, saying that it was because he had hurt his ankle. His little sister noticed the sores as he was changing his shirt, and told the parents. By that time, one infection measured 2" x 3", and the other one 2" x 2", on opposing sides of his lower abdomen.

When the child was first seen in the emergency room on Saturday, the parents were told that the infections were quite serious and that John would have to be admitted as an inpatient. However, when it was determined that the family lacked health insurance, they were told that he would be treated on an outpatient basis in the emergency room. The child was given morphine, but no local anesthetic, and the abscesses were cut open, drained and packed with dressings. The Youngs do not know the name of the resident or intern who actually worked on John. However, the attending was a Dr. Yeager.

TO: The Jonathan Harley ("John") Young file
FROM: Gordon Bonnyman
DATE: October 19, 1988
RE: Medical access horror story

The parents felt that, once it was learned that they lacked insurance, the staff seemed much more in a hurry to get John out of the emergency room than to take care to keep from hurting him unnecessarily. Pam became upset with the doctor, who she described as rude and uncaring in the way he treated John. (There was also apparently an exchange of words between a nurse and the treating intern or resident over the doctor's refusal to wear rubber gloves.)

The family was given a slip of paper telling them to return on Monday morning, October 17, to the Vanderbilt dressings clinic to have the packing removed and replaced.

On Monday morning the 17th, Pam Young took John back to Vanderbilt. They were at the hospital at 9:00 when the dressings clinic opened. However, they never made it to the dressings clinic. At the admitting office Pam was again questioned about her insurance and told flatly that John could not be seen at Vanderbilt because the family lacked insurance. Pam again explained, as she and her husband had explained on Saturday, that they had sufficient income to pay for John's care, but they just could not pay for it in advance. Such assertions did no good, and John went untreated. He was in pain, the infections continued to drain, and the original dressings had become nasty.

Turned away from Vanderbilt, John's mother then tried to find someone else who would care for him. At the Baptist Hospital emergency room and at two different pediatricians' offices, she was told that other providers would not intervene in a case which Vanderbilt had initiated and which was in mid-treatment. John remained with his parents in a hotel room at Union Station while the parents phoned around in a frantic effort to find someone who would care for him. They were referred to Legal Services by the Madison Church of Christ and by John Lozier with the Metro Health Department's Downtown Clinic.

When I spoke with them around 10:00 on Tuesday the 18th, they were both at work at the hotel, John staying in one of the hotel rooms while they worked. They were feeling increasingly anxious and trapped and were discussing driving 350 miles back to Muncie, Indiana, in hopes that their old pediatrician would agree to treat John. I agreed to contact Vanderbilt on their behalf.

I originally called John Callison in Vanderbilt's Office of General Counsel, but he was out until Tuesday afternoon, and I

TO: The Jonathan Harley ("John") Young file
FROM: Gordon Bonnyman
DATE: October 19, 1988
RE: Medical access horror story

spoke instead to Ms. Coleman Miller, staff attorney at the hospital (phone: 343-4001). I told her the Young's story: John's condition, the Young's willingness to pay for his care, the lack of compassion at the emergency room, the ER's referral of John to the dressings clinic and the dressings clinic's refusal to treat him, and finally the refusal of other providers to intervene in a case Vanderbilt had initiated. I gave her John's Vanderbilt patient number (0975538-0-8289). She said she would call me back. When I didn't hear from her I called her back in early afternoon, and then she finally called me back about 4:30, after I had already left for a meeting elsewhere.

On Tuesday night I called the Youngs at home in Dickson to try to give them some reassurance. Pam Young said she was just getting ready to put John in the car to drive to Muncie. I told her that I was reluctant to guarantee that I could get him care at Vanderbilt Wednesday, but that I was pretty confident I could. She decided not to drive to Muncie, but to wait to see what happened.

At 9:00 this morning I finally reached Coleman Miller. She said that she had called around the Medical Center and no one remembered or had any record of the Youngs having been to the Medical Center on Monday. She asked, "Did they ever actually come here?" She wondered if perhaps they had just been told they had to have a deposit and had never come. She said that in such cases, if someone doesn't have the deposit, they would call the doctor and if the doctor says it's an emergency, Vanderbilt permits the patient to be treated. In any event, she said that the Youngs should come to the hospital today and that John would be treated.

She said the dressings clinic was only open between 9:00 and 10:30, and that they would have to see a financial counselor by the name of Ms. Green first. Since it was shortly after 9:00 when we spoke, I expressed concern that they might not be able to get to the Medical Center and work through the red tape in time for John to be seen before the 10:30 closing of the dressing clinic. I asked if they could invoke her name if it looked as if they might not make it through the processing steps in time for John to be seen today. Ms. Miller said that she could not require anyone at Vanderbilt to treat the child, and that the Youngs would just have to do the best they could.

I relayed this information to the Youngs, who were still in Dickson. They said that they would leave immediately and thought they could get to Vanderbilt by 10:25. One of the parents would

TO: The Jonathan Harley ("John") Young file
FROM: Gordon Bonnyman
DATE: October 19, 1988
RE: Medical access horror story

take John to the dressing clinic and try to keep their foot in the door, while the other parent dealt with the financial counselor.

Pam reported back that she had gotten John into the dressing clinic to have the packing changed, and that he will continue to have to go back to Vanderbilt every two days until the wounds have healed. He is still on major antibiotics and is unable to go to school. She said that she spoke to Ms. Green, who commented at one point, "They really need to do a better job down there about their emergency room patients, they do this kind of thing all the time." Each visit to the dressings clinic costs the family $20.00 and they worked out a payment schedule that obligates them to pay Vanderbilt at the rate of $20.00 per week until all charges have been satisfied.

Pam said that she remains upset at the thought of this happening to other people. She said that John would never have gotten the care he needed but for the intervention of an attorney, and that she would like to do whatever she can to see that the same thing doesn't happen to other people. She is willing to talk to policymakers or others. I told her that I would be back in touch. I also told her that she has the right to file a Hill-Burton complaint under the Community Services rule.

Ætna

Personal Financial Security Division
Health Products
Policyholder Service Department
151 Farmington Avenue
Hartford, CT. 06156

EIN - 360

MICHAEL J JONES
5890 NW 64 TH AVE
TAMARAC,FL 33319

POLICY: CMP0056114

DEAR POLICYHOLDER:

WE ARE IMPLEMENTING A RATE CHANGE ON YOUR POLICY. THIS ADJUSTMENT WILL REFLECT THE RATE FOR YOUR CURRENT AGE AND MAY ALSO INCLUDE AN ADJUSTMENT FOR INCREASING MEDICAL CARE COSTS. ON YOUR NEXT PREMIUM DUE DATE, YOUR ANNUAL PREMIUM WILL INCREASE TO $6914.56.

WE CONSIDER YOU A VALUED CUSTOMER AND LOOK FORWARD TO CONTINUING TO PROVIDE FOR YOUR INSURANCE NEEDS.

SINCERELY,

POLICYHOLDER SERVICE DEPARTMENT
HEALTH PRODUCTS
AETNA LIFE INSURANCE COMPANY

09/14/88 109

AGENT: 7759E MATHEW SANTANGELO

Personal Financial Security Division
Health Products
Policyholder Service Department
151 Farmington Avenue
Hartford, CT. 06156

EIN - 360

MICHAEL J JONES
5890 NW 64 TH AVE
TAMARAC,FL 33319

POLICY: CMP0056114

DEAR POLICYHOLDER:

WE ARE IMPLEMENTING A RATE CHANGE ON YOUR POLICY. THIS ADJUSTMENT WILL REFLECT THE RATE FOR YOUR CURRENT AGE AND MAY ALSO INCLUDE AN ADJUSTMENT FOR INCREASING MEDICAL CARE COSTS.
ON YOUR NEXT PREMIUM DUE DATE, YOUR ANNUAL PREMIUM WILL INCREASE TO $4688.00.

WE CONSIDER YOU A VALUED CUSTOMER AND LOOK FORWARD TO CONTINUING TO PROVIDE FOR YOUR INSURANCE NEEDS.

SINCERELY,

POLICYHOLDER SERVICE DEPARTMENT
HEALTH PRODUCTS
AETNA LIFE INSURANCE COMPANY

09/15/86 109

AGENT: 7759E MATHEW SANTANGELO

Ætna
Personal Financial Security Division
151 Farmington Avenue
Hartford, CT 06156
(203) 273-0123

September 22, 1986

Mr. Michael J. Jones
5890 NW 64th Avenue
Tamarac, FL 33319

Policy No: CMP 56114

Dear Mr. Jones:

This is to confirm our telephone conversation of 9-18-86.

If you were receiving Social Security Disability Benefits prior to attaining age 65, we would not automatically cancel your policy. Cancellation would be your decision.

Since our conversation, I found out that to be eligible for Medicare under age 65, you must receive Social Security Disability Benefits for at least two and one-half (2½) years.

I also found out that I misinformed you regarding the premium reduction when you actually go on Medicare prior to attaining age 65. We cannot, be law, charge over age 65 rates until you have actually turned age 65. Therefore, the premiums will continue to increase each year for your actual age and for any approved rate increases. This fact may influence your decision on retaining your policy when you are on Medicare.

I've enclosed a brochure that you may find helpful.

If you have specific claim questions, feel free to call our toll free claim telephone number: 1-800-243-8093.

Please let me know if I can be of any further assistance.

Sincerely,

Rita Neddo

Rita Neddo
Policy Change Specialist
Health Products D216

cc: Sunshine PFSD Branch
Agent: 7759-E FO: 360

Ætna Life Insurance Company/Ætna Life Insurance and Annuity Company
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SUZANNE WEITZEL
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4040 Newberry Road • Suite 1400 • Gainesville, Florida 32607
(904) 372-4884

Abbey - Would you please help [illegible] the Weitzel See P 2 # 1+2 Thanks! Betsy

May 8, 1989

The Honorable Cliff Stearns
House of Representatives
1630 Longworth H.O.B.
Washington, D.C. 20515

Re: Joshua Benjamin Weitzel

Dear Mr. Stearns:

I am presenting a problem to you that my family faces as well as many others like ourselves. My husband and I are blessed with two excellent careers and two sons. My husband, Kent, is a dentist, and I am a physical therapist. We are both in private practices, and do well financially.

My son Erik is a bright 16 year old student at Buchholz High School and aspires to attend a good university where he plans on majoring in biochemistry. My son Joshua is 7 years old, and was born with a severe birth defect of the brain, an encephalocele. Joshua has gone through 10 brain surgeries since birth, and has had extensive therapy including a two year program at the Institutes for the Achievement of Human Potential, in Philadelphia, Pa.

My husband and I made the decision to raise Joshua versus putting him into an institution or cluster home. We love our son very much and want to help him through the home therapy.

Our situation is ironic since we want to help our son, but there are no means through the government, to our knowledge, that will benefit Joshua with our current income.

I have checked with Social Security, Medicare, H.R.S., and other governmental agencies seeking assistance. It seems unfair that the government will spend $30,000 per year or more per child for institution of the disabled, and not help those of us who earn incomes above $10,000 per year and wish to keep our children with us at home.

In these large facilities, the children are wards of the State, and do not get the best stimulation to overcome their problems. We know the care that children get at Sunland and it does not nearly meet the cognitive and physical stimulation that Joshua gets in our household.

Financially, we can care for Joshua in our home for considerably less, approximately $12,000/year, and provide him with personalized care.

I have worked hard for nearly 25 years supporting the federal system through income tax deductions, and I am concerned about the expense of running our federal system. We have a way to save money for the federal government. You should provide a way to assist families who raise their handicapped children in the home. You could make a difference by allowing energetic parents like Kent and I to raise our Joshua at home. There are many people like ourselves who wish to care for our children but we do not receive any compensation for a disabled child who in the future could conceivably wipe out our savings.

When Joshua reaches the age of 10, he will no longer be covered by our major medical policy and we will be without any extra coverage except regular Blue Cross/Blue Shield. Our present premiums from B.C./B.S. are very high, and continue to increase because of Joshua.

The federal government needs to address the following issue:

1. Save money by assisting hard working families to care for their disabled children at home, rather than having to institutionalize them.

We need assistance in primarily 2 areas:

1. Aide to assist with respite care which now costs us from $50.00 to $100.00 per day of our personal income.
2. Medical coverage through Medicare separate to the rest of our family who are in excellent health.

I would appreciate your thorough review of our dilemma. Please help us make the difference. We need support in Washington to voice our needs.

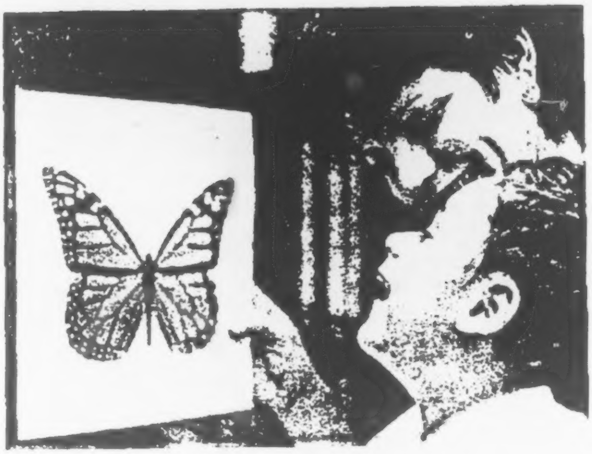
Let us know if we can be of any help to further this cause. I would be willing to bring Joshua to Congress and testify at any time. I feel if the Congress could personally see him, and other children like him, it would make the difference in swaying their opinions.

We appreciate your help.

Very truly yours,

Suzanne Weitzel

UPDATE



Dear Ann, Glenn and all of the staff
at the Institutes,

I was blind, and now I can see,
I was deaf, and now I can hear,
I felt no pain, and now I'm
even ticklish,
I'm drug free and seizure free.

Thank you for all you have done
for me.
May God bless you always,
I Love You,
Joshua Weitzel
6-10-88

2-15-89

Dear Nord,

I was glad to run across your organization in my travels thru CompuServe during my $15 free trial period. (I dropped it after my free trial - too expensive for non-local calls). It was also very nice of you to write me both in E-mail and to my house. I was very glad to get all your information.

The letters in the sample newsletter were fascinating - and how I could relate to those stories. I carried symptoms of my disease around for two and a half years before a doctor finally guessed as to what I had.

As long as I'm writing, I'll tell you my sob story. I used to be a prosperous forestry worker/contractor - in the business for 13 years when I started to feel a significant weakness in my limbs. At the time I had a good insurance policy - not that I had every needed it - but I kept it up for years because it was one of those things that my mother always told me I should do - like eating apple pie.

My weakness progressed to the point where my fingers could not coordinate putting a button thru the hole, or pull on a sock, or zip up a zipper. My knees and ankles were week, and I constantly stumbled and fell. I went to the doctor. He did every test under the sun on me, including an MRI. He said he didn't know what was wrong with me and sent me to the state University Hospital. They did even more tests, and repeated some. They said they didn't know what was wrong with me.

After a period of about 6 months I noticed I was gradually improving. I was getting better!!, and by the next summer I was back at my summer seasonal forestry work. During that summer I got a notice from my insurance company that - they were changing carriers, and due to my high bill that year, they had to up my rates - to $550 a month! That's over 50% of my gross salary (for work only nine months of the year too). I was forced to drop my insurance - in essence, my insurance company canceled me because they sensed a chronic disease (I bet).

Well - to heck with all of them - the insurance company, the doctors - I didn't need any of them as I was all better, and it must of been just a bad dream.

The summer progressed fine - the fall was great - and I spent the winter and early spring attending my local community college, waiting to go back to work. On the campus I noticed that funny feeling coming back into my feet - I ignored it. I got better before, and I would get better again.

On into the summer, and I was working in the field again. My job required me to walk over difficult forested terrain and write a lot of notes. I knew I was getting worse - I stumbled all the time - I could not lift heavy objects.

Then, one hot July morning things went wrong. Workers couldn't find their areas, other work areas were founded logged, an expensive piece of equipment was lost - then found again. About noon I started a new job - took out my notebook, held my pencil, all with great effort. I tried to make a fist - I couldn't, I tried to hold my fingers straight - I couldn't. Just like that my right hand had gone paralyzed. I was devastated. I could barely move my arm also. My left had was not as bad, but bad none the less.

I took a leave from my work. I cried, I didn't know what to do. My savings were meager. If I went back to a doctor, they would tell me they didn't know what was wrong with me, and I would be no better off - just broke. I tried to qualify for welfare - my car (1984 2-wheel drive toyota pick-up) was worth too much money. I could get welfare only if I sold it or ran it into a tree. I also had more then $50 in savings which also disqualified me.

I sat around the house - waiting to get better, but only getting worse. It was the worst time in my 40 years of life. I could not walk outside (uneven ground) without crutches. I could not get anything out of my pockets, including money. I could not cut my toe nails or fasten my cloths. I could not turn light switches (the twist kind). I could only type with one finger. I give my life mate a thousand thanks for being there for me at that time.

Then I started to think that maybe I would die. If I was getting worse every day, what was to stop me from just dying - and soon. I decided that even if it meant I had to sell all my possessions, I had to go to a doctor. A life of poverty and debt was better then death with a small savings. So, six weeks after my hand went paralyzed, I made an appointment with a neurologists I had never seen before (I was working near a different city then before).

This guy was great - he took me seriously, something I felt the other doctors did not do. He understood my financial situation, and kept the tests to the BEAR minimum. He guessed that I had a disease called Chronic Inflammatory Demyelinating Polyneuropathy, or CIDP for short. He gave me the drug Prendensone.

Within a month I was almost totally recovered. Now, 4 months later, I feel as strong and as coordinated as I ever have. (True, I've gained LOTS of weight, but so what). I'm decreasing my dosage, and I hope to go off the drug completely by June. If, later in my life, I have another relapse, at least I know what is wrong with me, and what I can do about it.

I certainly do have a love/hate relationship with the AMA. I hate that it is so expensive to get health care, and I feel cheated that the quality of care I receive if far less then those lucky or rich people who could get insurance. I love that I am not a cripple any more.

One last note on a recent development. When I moved back to my permanent home this winter, I changed doctors, and she told me I should have a nerve biopsy in order to get a positive diagnosis. I asked her how much that would cost. She didn't know. After extensive research, I finally found out how much the hospital would charge, but have given up further research in light of the long distance calls it would take me to find the surgeons fee, the anesthesiologist fee, the pathology report fee, and somebody else's fee, I forget now. What a tangled mess - just because I asked how much it costs *before* I have an operation. They certainly could figure it out fast enough *after* I have it. I've decided that I will not have this operation as I probably can't afford it anyway.

It does feel good to write all this down finally. Thanks for the shoulder. Enclosed you will find miscellaneous items you sent me to return.

Sincerely,

Roseburg, Or. 97470

TESTIMONY OF KITTY MCCAGUE
MARCH 9, 1989
HOUSE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

Chairman Waxman and Committee Members:

Thank you for inviting me to testify today about my experience with our country's health care system. The fact that I owe almost $150,000 in medical bills would be almost comical if it wasn't so representative of what's wrong with our country's health care delivery system. And tragically, my situation is not unique.

Two years ago I was carried into an emergency room of a health maintenance organization in Michigan with an acute case of endocarditis, an infection of the lining of my heart. A few months earlier I had quit a very good job because of my health problems. I started receiving unemployment insurance, but quit going to the doctor although my health worsened because I had no insurance. Like others without insurance, I waited until my situation was critical before seeking care again. I had about two days to live when initially admitted to the hospital.

After three and one-half weeks of ineffective antibiotic treatment, I elected to have open-heart surgery. A growth the size of a ping-pong ball had diseased one of my heart valves and I needed it removed to save my life. Surgery was successful and after four more weeks of I.V. antiobiotic therapy, I went home and began the move back to Texas where I grew up. I was anxious to get my life back in order.

I got a good job in Austin and health care coverage under a group plan which did not query me about my medical history. Soon severe backaches sent me to doctor after doctor who could not find the source of my pain which got progressively worse. Once again I quit work and was without health insurance, or an income. A friend from San Antonio offered me a job and I accepted, convinced my back pain would subside and I could work. Unfortunately, that didn't happen.

After a couple weeks I was back at the doctor, this time with an orthopedic surgeon who said the infection that had been in my heart was now in my spine. It had eaten parts of two vertabrae and the disk between them. A few days later I had emergency spinal surgery and a fusion. I left the hospital after two more months of I.V antiobiotic therapy, in a back brace which I would wear for six months. I had no income and couldn't work for some time. The Social Security Administration denied my claim although I had been battling the disease for nine months and would be disabled for at least six more months. They said I was employable.

But who would hire someone in a back brace with a medical history like mine? By this time, my medical bills were well over $130,000 and I still needed consistent monitoring by both cardiac and orthopedic doctors. Because of my financial situation I began looking for a job and doing freelance writing and editing. But the Texas economy was too slow. I came to St. Louis where I now live and after a few months had a great job that utilizes my skills in community organizing and politics. And appropriately, this time I would be working on health care issues. I know I am blessed to be working again, particularly with people who understand my medical problems and support me. They realize it gives me an insight into our health care system that others don't have the opportunity to see first hand.

When I was first hired my boss told me to shop around for health insurance which the organization would pay for. Since I was the only employee on my side of the state, I would have to get an individual policy. Phone calls around St. Louis yielded few options. First, there were only a couple individual plans and they told me upfront that my medical history would disqualify me. Another told me that if I did receive insurance it would not cover my preexisting conditions for some time. But these are the only medical problems I need to see a doctor about. Finally I found a staff model health maintenance organization which was founded by one of our board members. I requested an application. But after looking it over, I knew I would be disqualified if I was honest with my answers.

I returned the application without mentioning my cardiac and orthopedic problems. If accepted, I thought, at least I would have some much needed dental coverage and medical care in the event of another health problem. Or would I? I know if the HMO finds out about my omissions, I will be dropped and liable for any bills I incur. And either way, I still don't have health care coverage for problems that need to be constantly monitored. The lack of a tricuspid valve in my heart is fairly uncommon and I may need a fake valve put in sometime soon. Without one I now have ongoing symptoms of mild conjestive heart failure, and serious liver problems from disturbed blood flow dynamics.

My heart condition requires frequent visits to cardiologists at St. Louis University Hospital who have agreed to see me for free. Because of my work on health case issues, I know some of the 'right' people who pull strings for me. But most other people with serious health problems don't have this luxury; Americans shouldn't have to know someone in order to receive quality, affordable health care. It's just not a good way to run our health care system.

My spinal problems, however, are more indicative of what people without insurance experience. There's a possibility the infection I had is still in my spine and I've had severe back pain recently. I know from experience I need to see an orthopedic surgeon, but this is difficult - and costly - without insurance. Because the university's emergency room is also a trauma center, I spent a day there recently being seen for my spinal problems. However, I had to put down a $50 cash deposit and sign financial agreements before a physician would see me. The visit yielded little, except some very expensive X-rays and other tests and an appointment next week with a orthopedic surgeon. Seeking care in the emergency room was the only way I could get into their system. This seems like a backwards, and expensive, way to access health care and certainly not in line with any serious attempts at controlling costs.

Our health care system is seriously ill and in need of a major overhaul. It seems illogical and counterproductive that a person who is healthy enough to be employed fulltime is not healthy enough to get insurance, particularly for conditions that need to be monitored. Everyone is better off if people like me continue to work and pay taxes. But if I am unable to receive care for health conditions that could have been kept in check, I will once again become to ill to work. Then everyone starts paying the price. We have to look at long-term solutions and ask the ultimate question - should our health care system be profit motivated or people motivated? Should our health care system exist to line the pockets of insurance companies, hospitals and some doctors, or should it serve the public good and ultimately the interests of our nation?

And if our country is serious about controlling spiraling health care costs then we have to change the way people seek health care. Once again this brings up the profit versus people question. It costs all of us more when people wait until they are critically ill and seek care in an acute care setting, not only in dollars but in terms of human lives. Encouraging preventive medicine such as physicals and prenatal care would save all of us money in the long run. There are those here today who say this country cannot afford health insurance for all its citizens. I say we cannot afford not to. We have to get serious about what's really vital to the future of our country. Our country was founded on the individuality and stamina of its people. Without a healthy citizenry, how can we survive?

Submitted by Kayleen Anderson

417 10th Street A

Silvis, Illinois 61282

309-755-7160

I work with unemployed people at a dislocated worker center. I see the need daily for a National Health Care Program, especially for people between the ages of 30 to 50 who haven't any dependents. I also work with underemployed people who can't afford to pay for private sector health care on their own. There are people who can't accept employment offered to them because they would lose their public aid benefits and be without health care for their families.

I just recently got married. This is the first time in five years that my daughters and I have had health care insurance. The agency that I work for, which is federally funded, does not offer insurance and the cost of private sector insurance was too high.

Do any of you know what it is like to have sick children that need medical attention and not be able to afford it for them?

I have several incidents that I would like to share with you. Four 1/2 years ago my youngest daughter, Carrie, bit into an electrical cord. She received severe burns on her face and the left corner of her lip was gone. After healing, it was recommended by the family doctor that I she see a plastic surgeon. An appointment was made and the plastic surgeon recommended *that Carrie have lip reconstruction. I stated that I did not have insurance and his reply was to let him know when I did get insurance, surgery could be scheduled. The doctor also stated that this needed to be done within the next 5 years or before Carrie was ten. Standing there looking at the doctor I told him that I would call back soon, not realizing that it would be almost five years before I would have insurance to fix my baby's lip. Just four years ago I was working two jobs; one full-time, one part-time, just to make ends meet. My oldest daughter, Suzy, had been sick often with ear infections for over a month. Not being able to afford the cost of an office visit I was calling the doctor for a refill on her medication. While getting ready for work one morning Suzy came in to me complaining of not feeling well. So many things ran through my mind. If I take time off work that's one day's pay. If I find someone to take care of her, will the care be as good as Mom's? This is just part of the guilt that I've felt trying to work and raise two little girls by myself. Neither one of my jobs offered benefits. Looking there at my daughter I knew she was seriously ill. Her joints were swollen. Her knees were so big she could hardly walk and she was burning with fever. Three days later, after a series of tests,* *Suzy was diagnosed as having rheumatic fever with a detectable heart murmur. All this was caused from strep throat that was not treated. The ear infections that Suzy had been having was an additional problem. If I would have had insurance or able to afford a doctor, all of this could have been prevented. My daughter is now taking medicine and will continue to do so until the age of 21.*

I have contacted insurance companies about health care. The cost per month is $218 to $280. How can people afford this? The very reason I need health care was because of Suzy and insurance companies wanted to put her on ar a rider for 2-3 years. If she had problems in this timeframe the rider policy would be extended. The last 4 years without insurance has been a nightmare. Suzy has had 3 heart flutters and has been in the hospital emergency room 3 times. It's always the same questions: "Do you have health insurance? Then just how do you plan on paying for this? We would admit her, but with no insurance, we're sending her home. Watch for these symptoms and if she has any problems call us." Now let me tell you, the last thing on your mind is to call someone when your daughter is holding her chest, turning gray and passing out. Living 22 *miles from the nearest hospital your instincts tell you to get going. I had three times that the doctor's office would just call in medication for the girls because they knew I couldn't afford to pay for an office visit, Tables have turned and times change. I now have insurance. I can call the doctor and they'll give me an appointment the same day. Office personnel is nicer. They have quit asking me just how much I can pay and just how long it will take to pay off the balance. These questions are embarrassing and degrading. People are human beings with feelings and most are trying to do the best they can with what they have. This is people's lives that we're letting others play with. This has got to STOP! Insurance is a need for all humans, not just a privilege for a few.*

JUL 17 1989

MRS. SALLY A. SULEK
3421 Whittier Street
San Diego, California 92106
Tel. (619) 223-8212

July 11, 1989

* * * * * * * * * * * *

Congressman Walgren
U.S. House of Representative's
Room 2241 Rayburn Bldg.
Washington D.C. 20515

Dear Rep. Walgren,

We received in our office a bulletin from NORD in which on the front page it had an article about you. I would like to take this time to thank you for your work on the Federal Health Insurance Equity Act.

I never though that I would be in the predicament that faces me now. I have had the rare disease Interstitial Cystitis since 1983 but have been covered by the insurance at my husband's place of employment. Now, however, he is retiring and we are faced with holding onto his company insurance (if they will let us) at an astronomical price or trying to find an insurance company that will take care of me. Although my husband will be eligible for Medicare in 6 mo., if we stay covered with his company, we will have to pay for the same insurance at full price for 5 more years so that I will have coverage. Frankly, at this point we don't know which way to turn.

I am sure there are many other people in this same position or worse and I really applaud you for trying to do something about this problem.

Thank you again for taking up this cause and I wish you much success.

Yours very truly,

Sally Sulek

SALLY SULEK

7816 S. LATROBE
BURBANK, IL.
60459

SEPT. 5, 1989

Dear Congressman Walgren,

Thanks for introducing the Federal Health Insurance Equity Act (HR 2649). I read about it in the NORD Summer 1989 Orphan Disease Update.

Please tell me more (& send me a copy?)
How can I help?
I am in Marty Russo's district.

Best regards,
Jim Olszowka

JIM OLSZOWKA

CC: CONGRESSMAN RUSSO

I hope your bill can keep me out of bankruptcy + public aid. I am an accountant looking for an employer who does not have a pre existing condition exclusion in its medical policy. I changed jobs in 1989. My present employer lost its insurance coverage + is having trouble finding coverage which would include me. I have a son who has hemophilia. Like you, I have 3 sons; 13, 7, + 5 years old. Only one has hemophilia. We don't know where it came from. We can't find it in family history.

Can you help me get a job?

AUG [illegible]

August 7, 1989

Doug Walgren
U.S. House of Representative's
Room 2241
Rayburn Building
Washington, D.C. 20515

Dear Congressman Walgren,

I want to congratulate you for introducing the House Resolution (H.R.2649) which would provide insurance coverage for people with genetic disorders. I have had trouble obtaining such a coverage for a long time for our daughter and have been professionally also an advocate of such a law. It's a disgrace that the first nation in the world cannot provide medical care to individuals who are not at fault for not being able to provide the exorbitant fees and not have insurance policies to cover their own needs. Your bill would take care of that and would divide the costs, generally to all of us in this country. Again, I want to congratulate you for your foresight.

With Kindest Regards,

DSBorgaonkar

Digamber S. Borgaonkar, Ph.D.
2638 Bellows Drive
Brandywine Forge
Wilmington, DE 19810

Rep Doug Walgren,

SEP 11 1989

I would like more information on the "Health Insurance. Equity Act". I also would like to know what we can do to help pass this Bill,

I just reciently am getting involved in politics. I am a registered voter, but until reciently I didn't know or really care what our politicians did. Now I realize how important it is, like with this Bill which affects my family.

My 2 yr. old son Keith was born with a heart defect & DiGeorge Syndrome, up to date our medical Bills have totaled about $125,000. We're lucky we have very good insurance, But if my husband were to change jobs and insurance companies Keith probably wouldn't be covered.

He needs another open-heart surgery but not for 10 or more years, which means my husband has to stay at his present job that long whether he wants to or not just to keep the insurance.

I'm glad you introduced this Bill and I can't see any reason Why anybody wouldn't What it to pass, except the insurance company

Sincerely
Annette Mueller

Annette Mueller
1062 W9th Ave
Oshkosh WI-54901

STEVEN G. STORCH
9 EAST 37TH STREET
NEW YORK, NEW YORK 10016-2822
(212) 481-7755

September 13, 1989

Representative Doug Walgren
United States House of Representatives
Room 2241
Rayburn House Office Building
Washington, D.C. 20515

Dear Representative Walgren:

I am writing with respect to the proposed Federal Health Insurance Act (HR2649). I understand that enactment of this act would prohibit health insurance companies from excluding, terminating or otherwise limiting an individual from coverage based on a pre-existing health condition. As a parent of a six year old child who has developed a life threatening, long term illness, I am all too aware of reluctance of health insurance companies to assume coverage for a pre-existing condition. My son's medical expenses have amounted to hundreds of thousands of dollars to date. Fortunately, we have thus far been able to maintain our insurance.

My wife and I have, however, also met other parents who have not been as fortunate and we know of two people being forced into bankruptcy because of expiration of their health coverage and inability to obtain new coverage because of a pre-existing condition.

I would like more information about the proposed law and any suggestions as to what role concerned citizens could play in seeing it is enacted.

I look forward to hearing from you.

Respectfully,

Steven G. Storch

SGS/jm

cc: Senator DeAmato
Senator Moynihan

Ted & Linda Anthony
4421 Donnelly Avenue
Fort Worth, Texas 76107-5405
(817) 731-7079

September 9, 1989

Representative Doug Walgren,
Democrat, Pennsylvannia
United States House of Representatives
Room 2241
Rayburn House Office Building
Washington, D. C. 20515

Dear Representative Walgren,

Today I attended a parents support group meeting of "Our Special Children." One of the members, Vickie Baum, reported on the Health Insurance Equity Act (H. R. 2649). This information came from the "Orphan Disease Update" Volume I, Edition 1, Summer 1989. I am very interested in learning more about the proposed law. I would appreciate any information regarding this.

We have adopted four special needs children and as you can imagine, these children have a variety of pre-existing conditions. We belong to an adoption support group (Fort Worth Council On Adoptable Children, Inc) that has a membership of 263 families, and most of us have more than three children. A number of the adopted families have run up against the problem of pre-existing conditions. Some of us have subsidy's that help to defray some of the costs, but there is so much more that we incur. In the end the Federal Government is going to wind up picking up the tab if something can not be done about the problem of pre-existing clauses in private health insurance. People will not adopt the very needy children, if there is not some recourse to this situation.

Please send as much information as you can so that we can pass the information on to the members of our organization.

Thank you for helping the children of today and the future citizens of tomorrow. God Bless you and your family!

Sincerely,

Ted & Linda

Aug 24, 1989

The Honorable Doug Walgren
U.S. House of Representatives
Rm 2241 Rayburn Bldg.
Washington, D.C. 20515
attn: Glenda Booth

Dear Sir:

I have just received a bulletin from my doctor in Kansas City. I want to thank you for introducing your bill, the Federal Health Insurance Equity Act (H.R. 2649). I myself suffer from a craniofacial birth defect known as hemi-facial microsomia. I also have a deformed right ear, which has had some reconstruction. Before I joined the Federal Government in Washington, D.C. at the National Archives I experienced being denied coverage by my insurance company. They do not realize the psychological and monetary burden that this type of situation creates! I certainly hope you receive many letters on this. I am also writing to Senator Dole and Congressman Dan Glickman on this subject. At this time, I work at the Eisenhower Center and have health insurance from Government Employees Hospital Association. I had a dent near my right ear and they tried to call it cosmetic surgery. My doctor, John Hiebert at KU medical center tried to talk with them over the phone and they refused! This is a violation of OPM rules! I reported them to my Personnel office in St. Louis. I had the surgery preformed without the pre-authorization. GEHA has approved the orthognathic surgery, but not without a fight first! Before I can have this done, I need continued orthodontic work. I am going to tell you this as a case in point for which you might want to argue in the legislation process: I had braces placed on my teeth in 1984. In 1987 I became a permanent Government employee. I feel that since my right jaw is mal-formed due to the congenital defect, it is something which could be argued. What are your thoughts on coverage of braces when there is a deformity involving the mouth, cheek and jaw area? This is an aspect to consider in your legislation. My orthodontists in Virginia wrote 2 letters for coverage and GEHA denied to cover them. These braces have become a financial burden. I am having several doctors that I have went to, call Carolyn Cox at the Archives Personnel in St. Louis to discuss my case. I know I'm not as bad off as many other people but I feel the braces should be covered. I hope you will be able to perhaps investigate this, not for only me, but for all those who have craniofacial defects. Hope to hear back from you with your thoughts. Thank you again.

Sincerely yours,

Steve B. James
1108 N. Walnut
Abilene, KS 67410

Karen Bailey
1450 S. Irving
Denver, co. 80219

Dear Mr. Walgren,

I'm witing to obtain more information about the Federral Health Insurance Ewuity Act (H.R. 2649). I wish also to thank you for efforts. I recently had my Heath Insurance Co. First Far West go into liquidation. Five years ago I was dianonosed wiht cancer and now find myself without insurance. I carried my own individual poicy with them for 7 years. and with two other companies for eight years prior to that. I paid out well over 120,000 for health insurance only to find that when I will need it there will be nothing. No protection...no back up nothing,,,,

Thank you for your help

SEP 2 2 [illegible]

September 16, 1989

Dear Honorable Congressman Doug Walgren

I am writing in regards to H.R. 2649 (Federal Health Insurance Equity)
My wife has a, heart condition and Sjogens Syndrome. My employer has just cut my wages and is threatening to drop my Major Medical Groups Plan. Please, Sir. I urge you to please helps us People who can't get insurance because of pre-existing condition and companies who threaten to drop your insurance, that I have had for 16 years.
I thank you for taking time to read this letter.
Please respond.

Sincerely,
William T. Olney
2402 South ST.
Rolling Meadows, IL 6[illegible]

September 25, 1989

The Honorable Doug Walgren
House Office Building
Washington, DC 20515

Dear Mr. Walgren:

I write this letter with a despairing heart to ask your support of the Senate 6 (Robbins). This bill would make it possible for people who have pre-existing medical conditions to be eligible for health insurance. It seems ironic those who are unfortunately in bad health and need medical insurance the most, can't get it!

I am a victim of Multiple Sclerosis. For what most people take for granted, I struggle with on a daily basis just to survive. As if my health condition wasn't enough of a struggle, though I have insurance, why should I have to also struggle to get my medical bills paid? Please find enclosed a copy of my letter to Jerry A. Todd of the Customer Complaint Unit, with regard to the attached bills.

The expense of my Multiple Sclerosis condition is extensive, but without this essential care, my condition would be worse and more expensive.

Those of us with pre-existing medical conditions need~~s~~ insurance and need~~s~~ you to support SB 6.

Your compassionate concern and support is greatly appreciated.

Bless you,

Elise Matthews Blair

Elise M. Blair

Jerry A. Todd
Consumer Complaint Unit
Health Care Service Plan Division
615 S. Flower Street
Los Angeles, CA 90017
August 29,1989

Elise Mathisen Blair
14650 Sherman Way #103
Van Nuys, CA 91405
(818) 782/6368

Regarding: Blue Shield of California

Dear Mr. Todd,

Just recently Blue Shield of California paid claims for services rendered by Edward Wagner, DC from August, 1988 to March, 1989.

Since the date of March 31,1989 no further claims have been paid. Enclosed please find two copies, June 1989, of unpaid claims. Each states that additional information has been requested. Such information has not been requested for any time span after March 31,1989. It seems that Blue Shield of California is discontinuing my claim payments due to my diagnosis. Can you assist me in this matter?

At this time I give full authorization to the office of Edward Wagner, DC to handle any or all of this case. Dr. Wagners office is located at 6315 Bonsall Dr., Malibu, CA 90265. The office phone is (213) 457/5868.

Sincerely,

Elise Mathisen Blair

Elise Mathisen Blair

cc:
Wagner Chiorpractic
Michael Losow
The Honorable George Deukmejan
The Honorable Alan Cranston
The Honorable Tom Bane
The Honorable Doug Walgren

of California

EXPLANATION OF BENEFITS

CALL BOX D LODI, CA 95241
(800)792-5515, (209)369-1045

FOR THE CLAIM RECEIVED ON 07/10/8

E BLAIR
14650 SHERMAN WAY 103
VAN NUYS CA 91405

111300564

Your claim has been processed in accordance with t
subscriber's health plan coverage. Please see the rever
side for an important message.

PATIENT'S NAME	GROUP NO	SUBSCRIBER NO	CLAIM NO	PROVIDER OF SERVICES	DATE
ELISE BLAIR	101011 0000	560567392	04891930350500	WAGNER EDWARD D DC	08 11

111300564 00200

SERVICES BILLED	PROCEDURE NUMBER	DATES OF SERVICE MO	DAYS FROM	DAYS TO	YEAR	NUMBER OF SERVICES	AMOUNT BILLED	AMOUNT ALLOWED	MESSAGE SEE BELOW	APPLIED TO DEDUCTIBLE	PATIENT'S COPAYMENT AMOUNT	AMO PA
MISC. SERVICES	90070	06	14	23	89	3	144.00		1			0.
MISC. SERVICES	97145	06	14	19	89	2	60.00		1			0.
MISC. SERVICES	97145	06	19	19	89	1	18.00		1			0.
TOTALS							222.00					0.

MESSAGES:
1 WE HAVE SUSPENDED PROCESSING OF YOUR CLAIM SINCE WE REQUIRE ADDITIONAL INFORMATION FROM THE PROVIDER OF SERVICE. WHEN WE RECEIVE THE NECESSARY INFORMATION WE WILL RESUME PROCESSING AND GIVE YOUR CLAIM PRIORITY ATTENTION.

THIS IS NOT A BILL - RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS

BLUE SHIELD
of California

EXPLANATION OF BENEFITS

CALL BOX D LODI, CA 95241
(800)792-5515, (209)369-1045

FOR THE CLAIM RECEIVED ON 07/10/89

€ BLAIR
14650 SHERMAN WAY 103
VAN NUYS CA 91405

111300565 H

Your claim has been processed in accordance with the subscriber's health plan coverage. Please see the reverse side for an important message.

PATIENT'S NAME	GROUP NO	SUBSCRIBER NO	CLAIM NO	PROVIDER OF SERVICES	DATE
ELISE BLAIR	101011 0000	560567592	068919303F1900	WAGNER EDWARD D DC	08 11 8

111300565 00200

SERVICES BILLED	PROCEDURE NUMBER	DATES OF SERVICE				NUMBER OF SERVICES	AMOUNT BILLED	AMOUNT ALLOWED	MESSAGE (SEE BELOW)	APPLIED TO DEDUCTIBLE	PATIENT'S COPAYMENT AMOUNT	AMOUNT PAID
		MO	DAYS FROM	DAYS TO	YEAR							
MISC. SERVICES	97110	06	23	23	89	1	30.00		1			0.00
MISC. SERVICES	M0007	06	26	30	89	2	106.00		1			0.00
MISC. SERVICES	M0008	06	26	26	89	1	30.00		1			0.00
TOTALS							166.00					0.00

MESSAGES:

1 WE HAVE SUSPENDED PROCESSING OF YOUR CLAIM SINCE WE REQUIRE ADDITIONAL INFORMATION FROM THE PROVIDER OF SERVICE. WHEN WE RECEIVE THE NECESSARY INFORMATION WE WILL RESUME PROCESSING AND GIVE YOUR CLAIM PRIORITY ATTENTION.

26-262 138

5

THIS IS NOT A BILL - RETAIN FOR PERSONAL TAX AND MEDICAL RECORDS

Edmonds,Wash. Sep.17,1989

U.S. House of Representatives Re:H.R.2649 Health Ins.
Washington,D.C. 20515 Equity Act

Congressman James McDermott

Dear Mr McDermott:

I am writing to let you know of my appreciation for your concern cosponsoring the H.R. 2649 Health Insurance Equity Act; to prohibit health insurance companies from denying policies to people with preexisting health conditions, or raising the premiums so much that no one can afford it,or having medical coverage cancelled.

I have been diagnosed,not too long ago with a chronic illness,Sjogrens Syndrome, I am 48 years old.

At this moment I have medical insurance coverage,but, for how long?,or, what would happen if I had to move to another State or when the illness progresses.

If medical insurance companies are going to be insuring people,they must do it for every one and not just the healthy .

We need to keep this country a nica place to live not die.

The Sjogren's Syndrome Foundation informed me that as of August 3,1989, you have acted on this matter,and I am expressing my gratitude,please continue working until it is passed by congress.

Most sincerely

Teresa Degiorgi

Teresa S.Degiorgi

20601 - 77 Pl.W.
Edmonds,Wash. 98020

Edmonds, Wa. Sep. 25-1989

Congressman Doug Walgren
U.S. House of Representatives
Wash D.C. 20515

Dear Mr Walgren:

I enclose a photocopy of the letter I sent to my congressman Jim McDermott, for cosponsoring bill HR 26 the Health Insurance Equity act you introduced to Congress.

Thank you so much for helping the needy and ill.

Most sincerely

Rosa Elena Degeorgi

October 1, 1989

The Honorable J. Roy Rowland
U.S.House of Representatives
Washington, DC 20515

Dear Mr. Rowland:

I am writing to request your support of H.R. 2649. On August 12, 1987, I was diagnosed with Sjogrens Syndrome, a chronic autoimmune disorder marked by dry eyes, dry mouth and rheumatic dysfunctions. Fortunately, I was enrolled in a group health plan, but for many other accessability to such benefits is virtually impossible.

Everyday we, the victims of chronic disorders, live with the fear that insurance benefits will be cancelled due to overuseage or skyrocketing treatment cost. We experience esclating premiums due to serious diagnosis or are being denied insurance policies due to preexisting condition clauses. Living with a chronic disorder is stressful and trying. Added worry over medical expenses only heightens your frustration.

Your efforts in getting H.R. 2649 passed would be more appreciated than words could ever express. Living with a chronic illness is painful - both physically and emotionally, but knowing that someone is willing to stand in your corner not only lessens the pain but also brightens your day.

Sincerely,

Stephanie T. Boyd

Stephanie Tuvara Boyd
Atlanta, Georgia
Age 23

cc: Rep. Doug Walgren

October 17, 1989

Congressman Willis D. Gradison, Jr.
House Office Building
Washington, D. C. 20515

Dear Sir:

I am writing to request your assistance in co-sponsoring the Health Insurance Equity Act (H. R. 2649), which, if passed by Congress, will prohibit health insurance companies from denying policies to people with pre-existing health conditions. This bill is extremely important for people with serious and chronic disorders who are often denied insurance policies, or find that their policies are cancelled at the time in their lives when they need insurance the most.

H. R. 2649 has been assigned to the House Subcommittee on Commerce, Consumer Protection and Competitiveness chaired by Rep. James Florio (D-NJ). It is my understanding that Congressman Florio is running for Governor of New Jersey and is not expected to spend much time in Washington for the remainder of this year, and it is extremely important that he be convinced of the importance of H. R. 2649 and take the time to schedule and hold hearings in regard to this bill.

As I am sure you must be aware, the approximately 37 million uninsured Americans are not just poor people who cannot afford insurance. Many middle class families cannot buy health insurance at any price if they have a pre-existing illness.

At this point in time, my main objective in having your co-sponsorship lies in the fact that I have a child with Tourette's Syndrome, and, although not a terminal disorder, it is a devastating neurological disorder, and people with this disorder should not be denied full and adequate health insurance coverage. I do not want my child to be denied insurance either now or as an adult because of it.

Therefore, I respectfully request that you co-sponsor H. R. 2649 and endorse the same whole-heartedly. As the secretary of a prominent attorney and Judge in Ripley, Ohio, I well realize the "wheels of justice" sometimes turn slowly; however, the passage of this bill is of extreme importance to many, many people in order to provide fair and adequate health insurance benefits for all.

increase

9-14-1989

Dear Sir:

My son Nickolas was born March 7- 1988 with a rare disorder that is diagnosed as XXXXY Syndrome. He was born at 29 weeks and weighed 2 lb. 10 oz.

The hospital bills were $10 thousand when he was dismissed from the hospital. Our insurance paid this amount but the insurance has gone from $760.00 quarterly to 900.00 a quarter within a one-year period.

Please continue your support in helping parents with children with rare disorders. The disorder is so hard to accept and then the worry of having to pay such costly insurance payments adds to the worry.

Please continue your efforts!

6373 Country Fair Circle
Boynton Beach, Fl
33437

increase

SEP

Aug 29 89

Dear Sir,

I read today with excitement, that you are trying to pass a bill "Federal Health Insurance Equity Act" (H.R. 2649). Someone is starting the ball rolling, for "fair" & reasonable cost insurance.

I live in Fla., I will personally do anything to make a valuable contribution, to see this bill passed. My neighbors say they are willing to sign a petition, write a letter, whatever you say. They are also anxiously awaiting your reply.

We are at this time very discourged that the way existing govt programs are set up you have to lose everything in order to get aid. We are willing to provide housing, food, clothes, & our fair share of insurance cost. We do not want to become a burden to an already over burdened system.

Briefly my daughter suffered a rare disease, 2 yrs ag. Kawasakis" mucocutaneous Lymph node syndrome). It affects only children, cause unknown. The disease goes away. Unfortunelly 20% of the kids suffer anerysms. My daughter was one of the lucky 20%. Therefore "Uninsurable". She was insured at the time. But once the bills were paid they upped our payments to 560.00 a month. When we went to replace our insurance we were shocked with the results.

Fla has a program SCHA "State Comprehensive Health

Association." Unfortunely it isscheduale[d] to be terminated June 1990. I dont know what we will do then.

I realize this program wasn't perfect, but it was our only protection from financial ruin. She is not treated for condition, Deductible 2000 00. Two years ago I was totally unaware of the cracks, in our medical system. Many other people are also unaware of how the system really works

When I see ads to the public to protect themselves from breast cancer, diabettes, + heart disease, I'm amused because they are also not telling the public the whole truth - If your lucky enough to survive the disease. You'll get a new one "Unsurability."

Please sir, contine to push for legislation to protect innocents victims from disease. I realize some we cannot cure, but I believe the insurance co's unfair practice can be cured.

I know the insurance co's will fight this legislation all the way. But perhaps if we can't tackle the insurance co's Busbiness, + profit. Perhaps the government can start legislation to give people another source of protection + eliminate the profit of others misfortune

Sincerely

Monday August 28
1989.

The Honorable Doug Walgren
U.S. Representative
WASH. DC 20515

Dear Mr. Walgren,

I was happy to read that you had introduced the Federal Health Insurance Equity act. H.R. 2649. Happy? I was ecstatic!

Thank you very much for seeing the need to rectify an unfair condition. I agree that excluding or limiting coverage for people with pre-existing conditions is a form of discriminating (that's mine)

If a person has a malady that is covered through insurance with their present employer, but wishes to change jobs it is impossible to find like insurance with another company because of the pre-existing clause. One feels trapped.

My daughter suffers from MS. an incurable disease and thinks about changing jobs, but the ones she has approached all have insurance carriers that include the pre-existing clause. The country has lived with this clause as if it were set in cement - I never questioned that it could be different. We tend to accept as "our lot" that goes with being ill as if the one wasn't enough. Insurance should not be only for the "healthy".

Thank you for your energy and caring. I am writing letters to my Senators + representatives supporting this act.

Please send me any information on this proposal. I will be anxious to hear of its road to becoming a law - which it should be.

Thank you. Kristin Spinney

TIME INSURANCE COMPANY
515 West Wells
P. O. Box 624
Milwaukee, WI 53201
Telephone: (414) 271-3011

TIME

April 5, 1989

Mr. David Lusby

RECEIVED APR 17 1989

11512

Dear Mr. Lusby:

Development Team, Inc.
Case 74076-7

We have completed our underwriting review on the application submitted for Myra Shneider under the above subject case.

On the basis of Ms. Shneider's diagnosis of Multiple Sclerosis in 1981, we are unable to consider coverage.

Please advise the business of our action by forwarding a copy of this letter.

We regret our inability to be of assistance at this time.

Cordially,

Ronald J. Schaber, Jr., Underwriter
Employee Benefits--Underwriting

RJS/xF4

The Development Team, Inc.
2111 Wilson Boulevard, Suite 405
Arlington, Virginia 22201
(703) 525-2997

Harry L. Hall, President

May 11, 1989

Insurance Commissioner
Insurance Commission, Commonwealth of Virginia
1220 Bank Street
Jefferson Building
Richmond, VA 23219

Dear Commissioner:

Enclosed is a copy of a letter from Time Insurance Company to the agent for our company policy, Mr. David Lusby at Insurit Inc., 10560 Main Street, Suite 315, Fairfax, VA 22030.

The Development Team, Inc., a not-for-profit corporation in the state of Virginia, currently with four full-time employees, has been denied coverage in its group health insurance plan for one of its employees (who is just running out of her COBRA with a prior employer) solely on the basis of the fact that she was diagnosed with multiple sclerosis in 1981.

Is this denial of coverage legal in the state of Virginia?

Are there any provisions of law related to insurance or other factors which would permit The Development Team, Inc. to obtain group insurance for all members of its staff, including the person who was diagnosed with multiple sclerosis in 1981?

What advice do you have for us?

Cordially yours,

Harry L. Hall

Harry L. Hall

cc: Myra A. Shneider

COMMONWEALTH OF VIRGINIA

STEVEN T. FOSTER
COMMISSIONER OF INSURANCE

Box 1157
RICHMOND, VA 23209
TELEPHONE: (804) 786-3741

STATE CORPORATION COMMISSION
BUREAU OF INSURANCE

May 19, 1989

RECEIVED MAY 22 1989

Mr. Harry L. Hall
2111 Wilson Boulevard, Suite 405
Arlington, VA 22201

Re: Our File No. 89 138 009

Dear Mr. Hall:

Commissioner of Insurance, Steven T. Foster, asked that I acknowledge receipt of your letter dated May 11, 1989. We are concurrently contacting the insurance company, and as soon as they respond to our request, we will be better able to discuss the matter with you.

In the meantime, should you have any questions, please do not hesitate to contact us.

Sincerely,

Pamela Gillespie

Pamela P. Gillespie, CIE
Senior Consumer Services Representative
Life and Health Division
Telephone Number (804) 786-6867

PPG:ln

Glenna
FYI & please return
Jess

May 26, 1989

Jess Thoene, M.D.
C/O Abbey Meyers
National Organization for Rare Disorders
P.O. Box 8923
New Fairfield, CT 06812

Dear Dr. Thoene;

The following letter is in regard to our daughter, Alice LeeAnn. At six weeks of age she was diagnosied as having Histiocytosis-X, a very rare malignant blood disease. Currently, she is twenty months of age. Seventeen of her twenty months has has been spent in the hospital due to her disease. One hospitalization consisted of nine consecutive months, of which 69 days were in the Intensive Care Unit. She has under gone seven separate surgeries. Recently, LeeAnn completed eight total body radiation treatments. She still faces several more months of chemotherapy and numerous recontructive surgeries.

The cost of LeeAnn's medical needs has been exorbitant. Our insurance has a one million lifetime benefit limit. LeeAnn's care has totaled over $600,000.00, to date. With the vast medical care still required she will soon exhaust our insurance benefits, leaving her with no health insurance coverage at a very young age. Due to this foreseeable event we began to explore available options.

The options given us are very grim to say the least. Options made available are as follows:

1. SSI - Application was made for SSI in hopes of obtaining a medical card for LeeAnn. Being a middle income family of $30,000 per year, we were denied because "we make too much money". (Limit for a family of three in Kentucky is $1,200 per month gross)
2. Y-Spend down - After incurring $2,000 in medical expenses per month the program will cover any remaining expenses for that month. At $2,000 per month times 12 month we are liable for $24,000 of medical expenses PER YEAR. Leaving a total of $6,000 per year to meet all other living expenses.
3. Welfare - Validating David's being unemployable, the government assists with all expenses for the family - housing food, and medical expense for three people.
4. Divorce - As the mother is the primary care giver, thus rendering her unable to work at the time, mother and child would be eligible for all welfare benefits.
5. Bankruptcy - This destroys 12 to 15 years of work at establishing an excellent credit rating.

These options seem unreasonable and totally drastic. How are people, who are willing to work, but faced with extreme medical situations, expected to exist within the limits imposed by most of the government programs. We would like very much to keep our family together. Our commitment to this has already brought our daughter through some seemingly insurmountable odds. We are willing to work and provide our own housing, food, clothing and retain insurance on ourselves. However, without help for the catastrophic medical bills, our working will be in vain. Unless something is done soon our family will be facing not only a devastating disease, but also, POVERTY. This can be avoided if an effort is made by everyone.

Sincerely,

David Farmer
Dianna L Van-Farmer

David and Dianna Farmer

October 16, 1989

Senator Donald Riegle
1207 Dirkson Office Building
Washington, D.C. 20510

Dear Sir,

We are writing you today to ask your assistance in Co-sponsoring the Health Insurance Equity Act (H.R. 2649). As you may know this bill, if passed, will prohibit health insurance companies from denying policies to people with pre-existing health conditions.

We are the parents of a 20month old son with a rare metabolic disorder called Cystinosis. To date we have experienced in excess of $20,000.00 in medical bills for our son, and anticipate many thousands of dollars more in the future. We are lucky, we belong to an H.M.O., joining prior to Steven's birth, that so far have covered our expenses.

Our concerns are for our son's future. If he survives to adulthood medical expenses and obtainting insurance coverage will be of major concern.

There are 20,000,000 people affected by over 5,000 different rare disorders in this country, which doesn't even include millions of others with more common catastrophic health problems. Many of these people find obtaining health insurance coverage to be impossible. It just doesn't seem fair that those in need of health insurance the most should be denied it. Your assistance in passing this legislation would be greatly appreciated.

Sincerely,

Carl and Terri Schleuder
40476 Village Oaks Dr.
Novi, Michigan 48050

208 Belcoda Drive
Rochester, N.Y. 14617
August 1989

Debra has been
very busy at work
but plans on writing
you soon from
first-hand ex-
perience
B. Scott

Attention: Glenda Booth,
Dear Ms. Booth,

Please accept our sincere thanks for considering legislation dealing with the "waiting period," for pre-existing medical conditions, that is a part of most health insurance policies.

The onset of Cystinosis, a rare genetic disorder, hit two of my children when they were about 25 years old and it was a complete surprise to our family. As a result, the two girls have had kidney transplants. I should like to tell you of my daughter Debra's experiences with regard to the "waiting period."

She is on her own, unmarried and lives in Los Angeles. When she changed jobs a few years ago, it was necessary for her to carry and pay for health insurance through her former employer for one year at considerable expense to her. This was in addition to the health insurance coverage provided by her present employer (which wouldn't cover her pre-existing condition for a year). She was lucky she could work it that way even though it was quite a financial sacrifice for her.

Her employer merged with another company and her job was eliminated. In considering her next job, the main consideration was health insurance coverage - not which job she really wanted.

Now, however, her present employer is starting a new business and is looking for an insurance package for his employees. He, too, is affected by the "pre existing" provision since he is familiar with my daughter's case and doesn't want her to be wi out coverage for a year. In addition, there is another employee in similiar circumstances.

My daughter, Debra, does need routine medical care to maintain the transplant and to deal with the many side effects from the medicine she has to take including cancer, gout, high blood pressure gum trouble, skin rashes, etc. The cost for just the immune-suppressent drug she takes is $225.00 a bottle and she uses about 2½ bottles a month.

I hope this story will help you in your process of gathering information to support the need for this legislation.

Yours truly,
Bernice Scott (Mrs. Ross

SEP 08 1989

August 31, 1989

HONORABLE DOUG WALGREN
U.S.HOUSE OF REPRESENTATIVES
ROOM 2241
RAYBURN HOUSE OFFICE BUILDING
WASHINGTON D.C.20515

Dear Congressman Walgren:

I would like to introduce myself, my lovely wife Victoria and Daughter Catherine Elizabeth Baum.

On February 6, 1985 Vicki presented me with a beautiful daughter, Catherine Elizabeth. A few days later after all seemed "normal" we found out she had a very rare livor disorder (ASA) Argininosuccinic Aciduria. Only a few (12-15) are living in the world with this particular disorder. Only because one (1) of only (4) Metabolic Specialist are in Dallas, Dr. Charles Mize, he saved her life. She is doing pretty well despite some delays here and there.

Catherine is required, by her doctor, to maintain a very strict low protein diet, in part we bring in from West Germany monthly. Mead/Johnson has agreed to be the US Agent for us. EMPIRE BLUE CROSS/BLUE SHIELD OF GREATER NEW YORK, my corporate office is in N.Y., has refused since day one to provide out-patient-blood work up & etc even tho' the policy clearly states we are covered. We had full coverage prior to Catherine's arrival. Our family has had to obtain the services of an attorney for over three (3) years to fight Blue Cross and they still are Eighteen Months (18) behind. When we received out latest issue of N.O.R.D. we said a prayer for you and your involvement with us.

page 2

I have written Senators Phil Gramm, and Lloyd Bentsen for their support in your bill. Please keep us informed with your progress and if their is more information you need or if we can ever be of service to you, please don't hesitate to call us.

Vicki and I are working on a foundation to help families like us and children that need our support when their insurance company cancels or will not pay a claim.

We spend about $1000.00 per month on drugs, food and care that is not covered by insurance, that should be. The drugs are prescribed by Dr. [illegible] the food i [illegible] obtained at [illegible] [illegible], but still Blue Cross says "NO COVERAGE"

If you need to contact our attorney for information, his name is Mr. Marc Smith, Harvey, Hodes, Costello & Burman, 180 North LaSalle Street, Chicago, Illinois 60601-2804. Phone #31[illegible]-855 5000. I will copy his this letter also.

Thanking you in advance for your wonderful support. Thousands of families have their arms around you. Keep up the fight. God Bless you and your family.

Kindest Personal Regards:

Lou & Vicki

LOU, VICKI & CATHERINE BAUM
1400 Tanglewood Trail
Euless, Texas 76040
817-282 1447 or 817 282 1405 (Ans Service)

cc: Senator Phil Gramm
Senator Lloyd Bentsen.
Mr. Lee Corson (Chairman of The Board, Corson Furniture Industries

August 31, 1989

The Honorable Phil Gramm
Senator
Room Sr-370
Russell Senate Office Building
Washington, D.C. 20510-4302

Dear Senator Gramm:

Please find enclosed our issue from N.O.R.D. with reference to Congressman Doug Walgren's proposed Federal Health Insurance Equity Act (HR2649).

Our family is involved 100% with Blue Cross **NOT** paying medical bills for our four (4) year old daughter. I had insurance prior to Catherine's arrival and she was diagnosed with a very rare livor disorder (ASA), Argininosuccinic Aciduria.

Through our attorney, for four (4) years, they are only eighteen months behind paying monthly care for Catherine. Our policy clearly states that the care she receives at Children's Hospital in Dallas is covered but they still refuse. The treatment is always out-patient treatment.

This bill would be a tremendous help for thousands of families, not only in Texas, but all over the U.S., We need your support along with Congressman Walgren to see that these insurance companies are required to perform to the letter of the coverage. If not, heavy fines for the executives, and/or some type of punishment should be inforced.

Thanking you for your time and support.

Lou

LOU BAUM
1400 Tanglewood Trail
Euless, 76040

August 31, 1989

The Honorable Lloyd Bentsen
Senator
Room Sh-703
Hart Senate Office Building
Washington, D.C. 20510-4301

Dear Senator Bentsen:

Please find enclosed our issue from N.O.R.D. with reference to Congressman Doug Walgren's proposed Federal Health Insurance Equity Act (HR2649).

Our family is involved 100% with Blue Cross NOT paying medical bills for our four (4) year old daughter. I had insurance prior to Catherine's arrival and she was diagnosed with a very rare livor disorder (ASA), Argininosuccinic Aciduria.

Through our attorney, for four (4) years, they are only eighteen months behind paying monthly care for Catherine. Our policy clearly states that the care she receives at Children's Hospital in Dallas is covered but they still refuse. The treatment is always out-patient treatment.

This bill would be a tremendous help for thousands of families, not only in Texas, but all over the US. We need your support along with Congressman Walgren to see that these insurance companies are required to perform to the letter of the coverage. If not, heavy fines for the executives, and/or some type of punishment should be inforced.

Thanking you for your time and support.

Lou

LOU BAUM
1400 Tanglewood Trail
Euless, Texas 76040

Consortium for
Citizens with
Disabilities

STATEMENT OF THE

CONSORTIUM FOR CITIZENS WITH DISABILITIES TASK FORCE ON HEALTH

AIDS Action Council
American Academy of Child & Adolescent Psychiatry
American Association for Counseling and Development
American Association of University Affiliated Programs
American Diabetes Association
American Occupational Therapy Association
American Orthotic and Prosthetic Association
American Physical Therapy Association
American Rehabilitation Counseling Association
American Speech-Language-Hearing Association
Association for Retarded Citizens/U.S.
Epilepsy Foundation of America
Learning Disabilities Association of America
Mental Health Law Project
National Alliance for the Mentally Ill
National Association of Music Therapy
National Association of Protection and Advocacy Systems
National Association of Rehabilitation Facilities
National Council of Community Mental Health Centers
National Easter Seal Society
National Head Injury Foundation
National Multiple Sclerosis Society
National Rehabilitation Association
United Cerebral Palsy Associations, Inc.
World Institute on Disability

TO THE
UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

Submitted - November, 1989
Revised - January, 1990

CCD RECOMMENDATIONS TO THE PEPPER COMMISSION

EXECUTIVE SUMMARY

The Consortium for Citizens with Disabilities (CCD) urges the Pepper Commission to include in its recommendations to Congress methods to achieve full access to appropriate, adequate, and affordable health care for the nation's 43 million Americans with disabilities.

CCD supports universal participation in a national health care system which offers comprehensive coverage of health, personal, and support services. CCD expects this system to be pluralistic, involving the public and private sectors, and equitably financed.

CCD recognizes that implementation of a universal national health system is a major undertaking. Consequently, CCD endorses an evolutionary approach, which improves on the existing framework of health care enroute to a truly universal, complete and effective system of providing health, personal, and support services to all Americans.

CCD recommends the following principles and steps to achieve these goals:

BASIC PRINCIPLES

NONDISCRIMINATION: That people with disabilities of all ages and their families participate fully in the nation's health care system.

APPROPRIATENESS: That comprehensive health, personal, and support services be provided on the basis of individual need and choice, to ensure that decisions affecting the selection of service, timing, service setting, and provider reflect personal preference and maximum benefit to the individual, rather than cost-containment goals or coverage limits.

COMPREHENSIVENESS: That the nation's health care delivery system offer a comprehensive array of health, personal, and support services, including, but not limited to, acute hospital care, physician services, long-term care, mental health and counseling, rehabilitation, habilitation, maintenance, family support, and assistive devices, to ensure coordinated care across all service categories and sites of service delivery.

EQUITY: That payment for health insurance and services is equitably distributed, so that no individual, or public or private sector interest is expected to contribute a disproportionate share of financial resources.

STEPS TO IMPROVE HEALTH CARE ACCESS

NON-ACUTE SERVICES AND LONG-TERM CARE

Substantially improve access to non-acute services and long-term care in all components of the nation's health care delivery system.

PRIVATE HEALTH INSURANCE

Within two years, require employers and private insurers to extend the concept of continuation of health benefits to include the portability of benefits to allow employees with pre-existing conditions or with dependents with pre-existing conditions to maintain health insurance coverage when changing jobs, when employers change insurance companies, or when other changes occur concerning employer-sponsored health benefits which could adversely affect employee access to insurance.

Enact legislation to prevent private insurance companies from denying health insurance coverage to or otherwise discriminating against persons with pre-existing medical conditions, including disease, disability, disorder, impairment, or other health conditions.

EMPLOYER-SPONSORED HEALTH INSURANCE

Require employers to provide comprehensive health insurance for part-time and full-time workers and their dependents.

Extend employer-sponsored health benefit requirements to self-insured companies, currently protected under ERISA.

PUBLIC HEALTH INSURANCE

Medicare:

Expand Medicare coverage for comprehensive health, personal, and support services, including, but not limited to, rehabilitation, habilitation, mental health and counseling services, personal care, drugs, supplies, assistive devices, respite care, and extended care in home, community and institutional settings.

Within ten years, incrementally phase out the two year waiting period for individuals qualifying for Medicare on the basis of disability.

Medicaid:

Expand the mandatory service category under Medicaid to ensure access to comprehensive services, including, but not limited to, rehabilitation, habilitation, mental health and counseling services, personal care, drugs, supplies, assistive devices, respite care, and extended care in home, community and institutional settings.

Promote a buy-in program to allow low-income persons, small employers, and individuals with pre-existing conditions to purchase Medicaid coverage at income adjusted rates.

Eliminate Medicaid's institutional bias, so that all states provide access to comprehensive health, personal, and support services in all home and community settings.

Mandate Medicaid eligibility for children and adults who are technology-dependent living in home and community settings, regardless of family income or perceived risk of institutionalization.

Mandate expansion of the extent and scope of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program to ensure access to comprehensive, nationally uniform services to all eligible children, and to promote the prompt and thorough implementation of 1989 OBRA revisions to EPSDT requirements.

MILITARY AND VETERANS' HEALTH PROGRAMS

Recognize the value, need and the reciprocal impact of military and veterans' health programs in efforts to improve access to health care.

DRUGS AND SUPPLIES

Improve private and public coverage for drugs and supplies.

ASSISTIVE TECHNOLOGY

Improve private and public coverage for assistive devices and related services, including assessment, adaptation, training and follow-up services.

FINANCING

At a minimum, CCD supports the elimination of the cap on personal income subject to the Medicare tax to generate funds for improved coverage of health, personal, and support services, particularly in the area of long-term care.

Establish an equitable financing scheme that is capable of improving coverage unde existing health insurance programs and, ultimately, of providing for universal participation in a comprehensive national health system, including cost-sharing on the part of persons with disabilities and their families that is equal to that of their nondisabled peers.

RELATED EFFORTS AFFECTING HEALTH CARE ACCESS

PREVENTION

Support health promotion and disability prevention efforts, including services which prevent primary and secondary disabilities.

SHORTAGE OF PERSONNEL

Support increased funding for education and related programs to increase the supply of qualifed health care professionals and other personnel, including funding for scholarships for preservice and inservice training, and faculty development.

DATA

Improve the collection and analysis of data concerning health care and people with disabilities, including utilization, adequacy of coverage, cost of coverage and care, and prevention.

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CONSORTIUM FOR CITIZENS WITH DISABILITIES RECOMMENDATIONS TO THE PEPPER COMMISSION

INTRODUCTION

The Consortium for Citizens with Disabilities (CCD) appreciates the opportunity to provide members of the Pepper Commission with information and recommendations regarding access to health care, including long-term, for the nation's 43 million Americans with disabilities. This document revises the preliminary statement submitted to the Commission in November, 1989. It incorporates and expands on concepts presented in testimony to the Commission by Mr. Steve Monson, on behalf of CCD.

CCD is a working coalition comprised of nearly 65 consumer, service provider, and professional organizations which advocate on behalf of persons with disabilities. In referring to people with disabilities, CCD includes a person with a physical or mental impairment, condition, disorder, severe acute or chronic illness which limits or impedes ability to function. Such disabilities may occur as a result of disease, injury, sudden trauma, aging, or congenital anomaly. The undersigned members of CCD believe that people with disabilities should have full access to appropriate, adequate, and affordable health care, personal, and support services.

Like many Americans, persons with disabilities and their families routinely experience problems gaining access to health care. Some are shut out of the health care system completely. Others face inordinately high insurance premiums and cost-sharing requirements, restrictive eligibility criteria, and coverage limitations which effectively preclude access to needed care. The origin of these problems are varied, although, for an individual with a disability, they typically relate to one or more of the following: disability, age, employment status, income, and ability to obtain health insurance coverage.

The families of people with disabilities figure significantly in CCD's views on this issue. An individual's access to health care is often contingent upon a family member's employment, earnings, or insurance coverage. Additionally, frustrated attempts to obtain needed health services for a child, parent, spouse or sibling is emotionally draining for all family members.

Ultimately, CCD seeks universal participation in a national health care system which offers comprehensive coverage of health, personal, and support services. CCD expects that this system would involve individual and family, public and private resources in the use of, delivery of, and payment for an array of services in a variety of settings. People with disabilities of all ages would participate fully in such a system.

Recognizing that the implementation of a full-fledged national health care system serving all Americans is a major undertaking. CCD endorses an evolutionary approach, which builds on existing programs while striving to realize universal, complete and effective system of providing health, personal, and support services. CCD recommends the principles and steps described herein to achieve these goals.

HEALTH CARE ACCESS AND PERSONS WITH DISABILITIES

CCD recognizes that the Commission was established under the "Medicare

Catastrophic Coverage Act of 1988" to examine shortcomings in the U.S. health care delivery system and its financing mechanisms which limit or prevent access of all Americans to comprehensive health care. CCD further recognizes that the Commission is bound by the statute in carrying out its mission.

CCD is encouraged that the statute specifically directs the Commission to consider persons with disabilities in making its recommendations to Congress. Although individuals with disabilities experience many of the same problems concerning access to health care that affect other segments of the American public, many access issues are disability-specific or are exacerbated by the presence of a disability and warrant such special attention.

CCD views health insurance as the ticket for admission to the nation's health care system. It is not surprising, therefore, that people with disabilities find their access denied. The current system of health insurance, both public and private, is rampant with barriers for persons with disabilities and their families.

CCD is concerned that many people with disabilities are unable to obtain health insurance and, as a result, have diminished access to health care. According to the 1986 National Access Survey, the uninsured are less likely to use health care services and are more likely to be in poor health than the insured.[1] A study of school children with disabilities revealed that the likelihood of a child seeing a physician is 3.5 times greater if the child has insurance coverage.[2]

Disproportionately high unemployment among people with disabilities contributes to their difficulty in obtaining insurance for themselves and their families. Additionally, many people with disabilities are self-employed and only eligible for non-group coverage, work part-time and do not qualify for health insurance benefits, or work for small businesses which commonly do not offer employees health insurance.

Options for the working uninsured are limited. They can attempt to purchase individual health coverage through private insurance companies or pursue participation in a public health insurance program. Unfortunately, the private insurance market is fraught with barriers for people with disabilities and many workers, by virtue of their limited incomes, would be ineligible for publicly sponsored coverage.

Inadequate insurance coverage or underinsurance relative to the health needs of people with disabilities is a serious problem. Health insurance programs typically cover medically-related costs, such as inpatient hospital care and physician services. Coverage for non-medical, non-acute services, like rehabilitation, long-term care, and mental health services, is commonly limited or lacking. This coverage pattern is particularly harmful to individuals with disabilities since less medically intensive, longer term services are often of most value to persons with disabilities.

The experience of people with mental illness is characteristic of the underinsurance problem. Among the 153 million people with private insurance plans in 1977, only 82 percent were covered for inpatient care of mental health conditions, compared to almost universal coverage for other inpatient hospital care.[3] The difference was substantial for physician care also: 71 percent were covered for outpatient services for mental conditions, compared with 83 percent for medical conditions. Further, inpatient and outpatient mental health benefits are far less comprehensive, relative to medical coverage. Maximum benefits are lower, deductibles and coinsurance rates are higher, and the percentage of costs that are reimbursed are substantially smaller.

An estimated one out of every five Americans experience mental illness.[4] Given the scope and prevalence of mental illness, the gap in coverage for mental health services is appalling. It causes many people to go without the services they need, creates an undue burden on the public mental health system, and causes significant hardship for the families of persons with disabling mental illness.

People in need of rehabilitation services find even wider gaps in coverage of needed care, including physical therapy, speech-language pathology, audiology, and occupational therapy. Efforts to include basic rehabilitation services in proposed minimum health benefits legislation were undermined by the lack of existing coverage in employer-sponsored plans.

The problem of insufficient insurance coverage for mental health and rehabilitation services simply illustrates the serious inadequacies that pervade health insurance programs. People with disabilities need access to comprehensive service in a variety of settings. From a disability perspective, major shortcomings in the nation's health care delivery system will not be truly resolved until access to a range of appropriate and affordable services is guaranteed. For this reason, CCD is extremely pleased that the Commission is focusing on access to comprehensive care.

CCD is also pleased that the Commission is specifically charged with considering access to comprehensive long-term care services. Such attention is long overdue. Traditionally, long-term care, as part of an array of non-acute services has been neglected yet, for many people with disabilities, it is this sector of the health care system that holds the greatest potential to enable maximum function and independence. CCD cautions the Commission to avoid making artificial distinctions between categories of care and resist efforts to unnecessarily separate long-term care from the array of services available under the U.S. health care delivery system.

CCD recognizes that state health insurance risk pools are frequently viewed as a means of providing health coverage to persons who are currently uninsured. At least 13 states have established risk pools to provide comprehensive coverage to persons otherwise unable to purchase insurance for themselves. Collectively, these pools have enrolled approximately 25[illegible] individuals.[5]

CCD believes that state insurance risk pools do not represent a viable approach to ensuring access to health care for uninsured individuals, particularly people with disabilities. By design, risk pools experience adverse selection and higher than normal costs, as persons who are locked out of other insurance alternatives flock to these programs for coverage. Moreover, the premiums for many risk pools make them inaccessible to many low-income individuals.

The above comments are intended to provide Commission members with a sense of CCD's perspective in preparing this statement. The following sections focus on primary issues of concern for people with disabilities relative to shortcomings within the nation's existing health care system.

BASIC PRINCIPLES

CCD recommends that the Commission employ the following principles and strategies to craft a national health care delivery system and interim program refinements.

NONDISCRIMINATION. That people with disabilities of all ages and their families participate fully in the nation's health care system.

CCD believes that the inability of a substantial proportion of people with disabilities to participate in the U.S. health care system at a level which meets their needs relates directly to their actual or perceived conditions. CCD urges the Commission to recommend that health program eligibility and access to services reflect functional limitations and the need for care, rather than other factors, such as age or income.

Access to health care for individuals with disabilities cannot be considered in a vacuum. Discrimination on the basis of disability limits opportunities in employment, education, travel, health care and other aspects of daily life. It is in these areas, including the nation's health care system, that people with disabilities, precisely because of their disabilities, are placed at a disadvantage.

The Commission's deliberation over the shortcomings of the American health care delivery system coincides with consideration of the Americans with Disabilities Act (ADA). This landmark legislation is aimed at eliminating discrimination against people with disabilities in private sector employment, public accommodations and services, transportation, and telecommunications.

Barriers to health care and related services for people with disabilities undermine the long-term success of ADA. Healthy individuals, who happen to have disabilities, join most Americans in voicing frustration with the inadequacies of the current health care system. For these individuals, problems of access to health, personal and social services compound the difficulties they experience when confronted by barriers to employment, transportation, telecommunications and other areas targeted for improvement under ADA.

For people with severe or chronic disabilities, however, the pursuit of opportunities arising from the passage of ADA depends on better access to broad health services. Worksite accessibility is useless to someone who needs, but is denied, ongoing physical therapy to secure and sustain a job. Public accommodations, in supermarkets, restaurants, and clothing stores, are ineffective if prospective customers cannot obtain the assistive devices required for mobility within the community.

Passage of the Americans with Disabilities Act will eliminate significant barriers to individuals with disabilities seeking to participate fully in the mainstream of American life. CCD urges the Commission to develop recommendations for health system reforms that are consonant with the goals of the Americans with Disabilities Act.

APPROPRIATENESS. That comprehensive health, personal, and support services be provided on the basis of individual need and choice, to ensure that decisions affecting the selection of service, timing, service setting, and provider reflect personal preference and maximum benefit to the individual, rather than cost containment goals or coverage limits.

Meaningful access to health care directly translates into the ability to receive appropriate services in appropriate settings by appropriate practitioners, as determined by individual need and choice. Limits on the scope, duration, setting of care, and on the type of care provider undermine the quality and effectiveness of service.

CCD believes that most private and public health insurance programs inappropriately restrict access to health, personal, and support services, in full or in part, to the detriment of participating individuals. The impact of these restrictions is particularly harmful to people with disabilities.

The National Multiple Sclerosis Society recently learned of Mrs. G, a woman with chronic progressive multiple sclerosis who was unable to obtain care in her home, which, in the opinion of Mrs. G and her family, was the appropriate setting for care.[6]

Mrs. G is 42 years old, married, and the mother of three children. She is frequently bedridden, has bowel and bladder problems and severe limitations in the use of her arms and legs. Her husband's health insurance covers home health care, provided that it is delivered by a registered nurse. However, the insurance company only pays $6.00 an hour for home health care and, as a result, no practitioner is willing to assist Mrs. G at home.

Mrs. G's family is ineligible for Medicaid or other assistance and has reached the limit on alternative services covered by their insurance plan. The family is desperately seeking help. Although Mrs. G wants to remain in her home, to do so without attention endangers her life.

For Mrs. G and her family, inadequate payment for a covered home health service is an obstacle to appropriate care. For other persons with disabilities, appropriateness may be compromised for other reasons. Regardless, CCD believes that the Commission should adopt appropriateness of care as a fundamental tenet in attempting to resolve shortcomings in the nation's health care delivery system.

COMPREHENSIVENESS. That the nation's health care delivery system offer a comprehensive array of health, personal, and support services, including, but not limited to, acute hospital care, physician services, long-term care, mental health and counseling, rehabilitation, habilitation, maintenance, family support, and assistive devices, to ensure coordinated care across all service categories and sites of service delivery.

The nation's health delivery system offers a wealth of services that protect and restore health and functional ability. These services are found in many settings delivered by many types of providers. They can be characterized individually, as types of services, including physician services, physical therapy, audiology, attendant care, and rehabilitation counseling, and collectively, as programs of service, including primary care, rehabilitation, habilitation, long-term care, and prevention.

For the purposes of this statement, comprehensiveness implies the broadest set of services that assist individuals with disabilities and their families achieve and sustain optimum physical and mental function. The term "health, personal, and support services" is used by CCD to illustrate the breadth of care necessary to ensure a truly accessible health care delivery system. In whole or in part, this term is not intended to be restrictive, exclusive, or exhaustive. Instead it refers to the universe of health services, including those listed above, as delivered by a range of practitioners in all sites of care.

Over the course of a lifetime, people commonly require health, personal, and support services from a broad array of services comprising the nation's health care delivery system. Access to comprehensive services is particularly important to people with disabilities. Many people with disabilities are distinguished from other individuals by the presence of predictable needs and higher utilization levels of acut and non-acute health care services.

People with disabilities and their families are routinely frustrated in their efforts to obtain services that are really comprehensive in nature. Too often, other factors, such as gaps in insurance coverage and high cost, curtail their access to one or more aspects of the health delivery system, and insodoing, erode the comprehensiveness of service.

CCD suggests that Commission members consider the experiences of people with traumatic head injury and their families, focusing on the difficulties they encounter in seeking access to comprehensive health, personal, and support services.

Over two million people receive head injuries annually, with 500,000 of those serious enough to require hospitalization. Head injuries may lead to death, coma or long-lasting disabilities, such as paralysis, epilepsy, dementia, or loss of hearing or vision. People with head injuries often require intensive emergency treatment, comprehensive acute care, rehabilitation and long-term care, including ongoing community support services. To date, the nation's health care system has failed to provide adequate access to the comprehensive services required to meet the unique needs of this population.

A 1989 Department of Health and Human Services report called for measures to increase local community programs for emergency services, acute care, clinical care and rehabilitation and long-term care for persons with traumatic brain injury (TBI), including the financial and legal reforms needed to insure the availability and accessibility of TBI care.[7]

"Prehospital care represents an opportunity to reduce significantly the mortality and morbidity of traumatic brain injury (TBI). Two-thirds of TBI fatalities occur before hospitalization; a major preventable cause of mortality and long-term disability is directly related to early respiratory problems and shock." Improving access to effective, prehospital emergency care would minimize the severity of head injury which, for survivors of severe brain trauma, can typically mean five to ten years of intensive services at an estimated cost in excess of $4 million.

The report states that "TBI has an economic impact on thousands of victims left partially or totally disabled, unemployable or dependent on their families or on state or federal sources; this includes both civilian and military populations. While great strides have been made, serious gaps remain, particularly in the post-acute period where optimal care is either unavailable or inaccessible to a large portion of the population. Patients are often forced to travel great distances from their homes to obtain post-acute care. This usually increases overall costs and complicates attempts at community reintegration."

Although a large proportion of survivors of head injury are able to resume active lives, with only minimal assistance, a significant subgroup of these individuals may need years of care, rehabilitation, and support services. Limits on these services jeopardize full recovery and opportunities to lead independent lives in the mainstream of society.

The need to improve access to comprehensive health, personal, and support services for persons with head injuries and their families is equally important to other persons with disabilities. CCD believes that the principle of comprehensiveness must be actively engaged throughout the Commission's work in assessing the nation's health care delivery system and making recommendations to Congress regarding its improvement.

EQUITY. That payment for health insurance and services is equitably distributed, so that no individual, or public or private sector interest is expected to contribute a disproportionate share of resources.

Access to health insurance and health care is not readily achievable unless premiums, deductibles and copayments are affordable to consumers. Fourteen million Americans decided not to seek needed medical care in 1986 because they could not pay for it. Another one million sought needed care and were denied it by doctors and hospitals because of their inability to pay.[8]

Eva and Melvin Phillips of Takoma Park, Maryland owe thousands of dollars for hospital care and prescription medicines. Most of this debt was incurred by Mrs. Phillips, who has chronic asthma, arthritis, and glaucoma. The Phillips are among the working uninsured. They earn too much to qualify for Medicaid, but cannot afford to pay $300 per month for private health insurance.

Mrs. Phillips has deferred some visits to the doctor so that the family can better afford care for her young grandson. Ultimately, however, she fears that deferring these visits will catch up with her and lead to a stay in the hospital. A single hospitalization will cost the family more money than the several trips to the doctor would have cost.

"It just goes on the same way," Mrs. Phillips said. "You never get out. You never get your head above water."[9]

The Phillips' story is not unique. People with disabilities and their families are commonly faced with difficult choices pitting the need for health care against the use of scarce financial resources. Consequently, issues of equity and affordability are paramount in the disability community's views on access to health insurance and health care.

As a group, people with disabilities have lower incomes than the general population. They are three times more likely to have incomes at or near the poverty line. Yet costs associated with access to the health delivery system for people with disabilities are commonly higher than for those individuals without disabilities.

High private health insurance premiums for persons with disabilities, often as high as 200 percent of the standard cost, represent a substantial barrier to coverage. Simply being deemed eligible to purchase a policy is not particularly helpful if the policy costs are so high as to be unaffordable or present an undue burden on household financial resources. Furthermore, the coverage purchased by people with disabilities, even at exorbitant rates, often provides fewer benefits and requires sizable out-of-pocket outlays for medical expenses, due to disability-related insurance policy limitations.

Many people with disabilities and their families are already devoting a disproportionate share of their incomes to health care and disability-related services. According to the United Cerebral Palsy Association, only one percent of families, when asked about disability-related expenses for children with chronic illnesses, were able to bear the additional expense of supporting a family member with a disability without outside help.[10]

CCD believes that people with disabilities and their families are willing to pay their fair share of costs associated with access to health, personal, and support services. However, the Commission is encouraged to develop and recommend to Congress financing and funding mechanisms that promote equitable investment and disbursement of individual, family, public and private resources.

STEPS TO IMPROVE HEALTH CARE ACCESS

CCD recognizes that the implementation of a national health system is a major undertaking. Consequently, CCD endorses an evolutionary approach which improves on the existing framework of health care, enroute to a truly universal, complete and effective system of providing comprehensive health, personal, and support services.

The following recommendations lay out the necessary steps to improve health care for people with disabilities in the current environment and under a truly comprehensive national health care delivery system serving all Americans.

NON-ACUTE SERVICES AND LONG-TERM CARE

Even if their primary, acute-care needs are similar to those of persons without disabilities, many people with chronic conditions have functional limitations which require rehabilitation therapies, such as physical therapy, occupational therapy and speech-language pathology services, in order to achieve and maintain optimum function.

Some people with chronic conditions may also require ongoing health, personal, and support services to maximize their health, independence and participation in community life. These services can include: psychological and mental health services; durable medical equipment; orthotic and prosthetic devices, including materials, components, tools, or equipment used in providing patient services in orthotics and prosthetics; personal assistance with self-care needs; drugs; disposable supplies; and, service coordination.

Although many people with chronic conditions are not sick, they may have thinner margins of health and would benefit from access to preventive services. The families of persons with disabilities, who frequently devote substantial emotional and financial resources to relatives with disabilities, benefit greatly from access to support services.

Unfortunately, the nation's health care delivery system has historically emphasized the provision of acute care and physician services over broader, longer-term services frequently needed by persons with disabilities. This is true for the public and private sectors.

Medicare was designed to pay for hospital and physician services, with only cursory attention, translate resources, targeted on other types of care. It was not structured to address the long-term and personal care needs of persons with chronic illnesses and disabilities, that is, to help people function as independently as possible as long as possible. Nor was Medicare set up to cover the costs of extended institutionalization.

Almost by default, Medicaid has become the chief payor for long-term care services, currently covering about 40 percent of the nation's nursing home bill. But Medicaid's means-tested eligibility criteria and bias against covering care in home and community settings renders it inadequate to the needs of many people with disabilities.

Private nursing home insurance is increasingly available, though often not to persons with pre-existing conditions. When available, it is frequently unaffordable. According to a recent study conducted by the Families U.S.A. Foundation and the United Seniors Health Cooperative, only the very richest elderly can shoulder the cost of long-term care insurance. Among those aged 65 to 74, only one in six can afford private nursing home insurance. Annual premiums averaged $1,255 when bought at age 65, but climbed to $3,860 when purchased at 79 years of age.[11]

The nation's health care delivery system is particularly deficient in providing access to long-term care. Long-term care, which may include nursing home care, home health services, and rehabilitation, benefits persons of all ages. Long-term care is, by definition, a response to social and psychological needs. The availability of extended, non-medical services can frequently mean the difference between allowing an individual to remain in the community and initiating a much costlier institutionalization.

CCD requests that the Commission consider the unique long-term care needs of young persons with developmental disabilities or disabilities acquired early in life. Care for these individuals should include pre-vocational and training services, supported employment services, supported living arrangements, assistance with learning and performing functional activities, such as food purchase and preparation, money management, and transportation. Personal attendant care and other services geared to helping individuals become and remain more independent are critically important. A comprehensive approach is needed for children, teenagers and young adults who are currently prevented from being productive because they lack access to the significant assistance they need to function well in the mainstream of society.

CCD is concerned about the unique and potentially substantial needs of infants and children who have disabilities or are at significant risk of developing them. The projected long-term needs of two groups of children, in particular, concern the disability community. These are children who test positive for HIV infection and babies born to mothers using drugs, particularly cocaine, and alcohol during pregnancy.

The Center for Disease Control projects that, by 1991, at least 10,000 to 20,000 children will be HIV infected. Of these, an estimated 93 percent will have developmental disabilities that result in some degree of mental and/or physical impairment. HIV infection in infants often leads to opportunistic infections, particularly in the lungs.[12]

Babies born to women who used cocaine during the early stages of pregnancy face five times the risk of serious kidney and urinary tract malformations.[13] Children born to mothers who drink alcohol during pregnancy also comprise a high risk group. Children with fetal alcohol syndrome experience a range of mental and physical impairments that require specialized attention and care. Health care providers voice concern over the ability of the service delivery system to meet the special needs of these children and their families.

Most insurers resist paying for rehabilitation and habilitation services, especially in home and community settings. They view the coverage of these services as an extension of the definition of health care. However, for people with disabilities, access to rehabilitation, habilitation, and mental health services is often the best, if not only, means of maximizing functional ability and reducing dependency.

A person with a spinal cord injury, for example, may have to relearn basic skills, like eating and washing, and acquire new ways of getting around both inside and outside the house. For this individual, the rehabilitation process many involve learning how to use adaptive equipment, such as breathing/handling aids (e.g. respirators, head pointers, mouth sticks), mobility aids (e.g. various types of braces, wheelchairs, crutches) and communication aids (voice synthesizer, special telephone), and modifying the environment to accommodate impairment.

Many insurers fear the costs associated with these services. Yet, rehabilitation, habilitation and other non-acute services are generally cost-effective. The Health Insurance Association of America concluded that for every dollar spent on rehabilitation, $11.00 is saved in other benefits that would otherwise have been spent on the affected person.[14]

For many people with chronic disabilities, long-term personal and support services are a necessary part of the care they need to sustain maximum functional ability. With ongoing access to therapy and other services, even for only one or two hours on an intermittent basis, many persons with severe chronic conditions can live more independently, enjoy better health, and lead more fulfilling lives. Assistance with personal needs, such as housework, meal preparation, bathing and dressing, is often the deciding factor in enabling an individual with a severe disability to live at home or hold a job.

Lastly, CCD views family support services as a key element in the reformation of the nation's health delivery system. The families of people with disabilities willingly assume the lion's share of financial and emotional responsibility for providing needed care and support. The costs of this effort, however, are staggering. Broader insurance coverage is needed for family support services to enable families to continue as major contributors to the care of relatives with disabilities.

Respite care is a good example of this support. Respite care, in the form of child or adult care, offers family members and other caregivers a temporary break from caregiving. For a relatively small amount of money, respite care helps families that are often experiencing high levels of stress cope with the demands of caring for persons with chronic needs. By the same token, the availability of respite care enables large numbers of people to live at home or in the community, who would otherwise enter institutions.

The value of respite care was the focus of a recent article portraying the experience of one family with a child with epilepsy. Helen and Mike Greenberger of Lakewood, New Jersey have a six-year-old son named Eric who has frequent, strong seizures. At one point, Eric was having 15 seizures daily and required the constant attention of his parents.[15]

For Helen and Mike, dealing with the unrelieved tension of Eric's disability began to break apart their relationship. Except for two hours each year, when a relative came in and cared for Eric as a birthday gift to his parents, the Greenbergers were never alone.

Relief appeared in the form of a local agency, which offered to provide respite care to the family using government funds. For the Greenbergers, the difference was considerable. "I'm a happy person," Helen said. "We can go out as a couple. We have friends now that we can socialize with. Our life has changed 100 percent."

CCD recognizes the value of respite care and is encouraged by increased reimbursement for this service under Medicaid. The unfortunate repeal of Medicare catastrophic coverage, however, which included a respite care benefit, will force many families of Medicare beneficiaries to forego this valuable service. Access to respite services can make a tremendous difference in the lives of families of persons with disabilities and warrants a recommendation by the Commission for greatly expanded respite care coverage.

Glaring inadequacies in access to non-acute services, long-term care, personal care and the range of individual and family support services constitute a most serious problem for people with disabilities. These services represent the key to better lives for many persons with chronic conditions. Yet, it is in this area of the health care delivery system that public and private health insurance programs consistently fail to meet the needs of people with disabilities and their families.

CCD urges the Commission to recommend substantial improvement in access to non-acute services and long-term care in all components of the nation's health care delivery system.

PRIVATE HEALTH INSURANCE

Most Americans have some form of private health insurance. Most private insurance is generally associated with employment and higher incomes and tends to cover healthier individuals. People with disabilities are frequently at a disadvantage in the private insurance market, for reasons having to do with income, type of employment, and discrimination on the basis of disability.

Individuals with disabilities and people with dependents with disabilities who obtain health insurance through employment encounter many of the same problems faced by nondisabled workers. They also face a host of disability-related barriers.

Job mobility, in addition to access to care, suffers for workers participating in employer-sponsored group health plans who have a disability themselves or have a dependent with a pre-existing condition. The threat of losing health insurance for themselves or a family member with a pre-existing condition when changing employers essentially holds these workers hostage in their jobs. Workers with disabilities and employee dependents with disabilities can also lose access to health insurance when their employer changes insurance companies or administering service agencies and the new companies or agencies deny coverage on the basis of pre-existing conditions.

CCD finds the jeopardization of health insurance coverage when people change jobs or employers change health insurance plans unfair and intolerable. Employees who have been insured under an employee-sponsored plan should have continued access to coverage under a new insurance company or administering service agency or with a new employer. CCD believes that the concept of "continuation of benefits," which currently ensures access to health insurance for up to 18 months after termination of employment, should be extended to include "portability of benefits," to guarantee coverage for people who change jobs or work for employers that change insurers.

CCD urges the Commission to recommend that, within two years, employers and private insurers be required to extend the concept of continuation of health benefits to include the portability of benefits to allow employees with pre-existing conditions or with dependents with pre-existing conditions to maintain health insurance coverage when changing jobs, when employers change insurance companies, or when other changes occur concerning employer-sponsored health benefits which could adversely affect employee access to health insurance.

Only seven percent of the U.S. population purchased an individual health insurance policy in 1985.[16] It is unlikely that this figure contained a significant number of persons with disabilities. Individuals with disabilities wishing to purchase a non-group health plan find it very difficult to do so. Categorical exclusions and restrictive underwriting practices employed by insurance companies which select against high-risk applicants, defined as people with Type I diabetes, AIDS, epilepsy, mental illness and other conditions, result in the routine denial of coverage for persons with these disabilities. Because of their disabilities, these individuals are often locked out of the private health insurance market, regardless of ability to pay or actual personal patterns of health care utilization.

Insurance companies willing to underwrite an individual health policy for a person with a disability usually do so with various types of limitations. The most common of these are exclusion riders, waiting periods for coverage related to the pre-existing condition, and severe limitations on types of benefits offered. Substantially higher premiums are frequently charged for such policies.

Exclusion riders are used to define the specific set of conditions which will not be insured under the policy. These restrictions may be applicable to a pre-existing condition, but may also restrict coverage in the event of a future illness

Some policies for persons with pre-existing conditions require waiting periods of up to three years in length prior to the onset of coverage. Under such policies, coverage for services associated with an excluded condition, such as cancer, schizophrenia, or heart disease, will not begin until after the waiting period has passed.

Discrimination on the basis of pre-existing conditions is extremely prevalent and problemmatic for people with disabilities and their families. **CCD strongly urges the Commission to promote the enactment of legislation to prevent insurance companies from denying health insurance coverage to or otherwise discriminating against persons with pre-existing**

medical conditions, including disease, disability, disorder, impairment, or other health conditions.

EMPLOYER-SPONSORED HEALTH INSURANCE

CCD believes that employment, which is already the primary means of obtaining health insurance for most Americans, is an appropriate vehicle for extending health insurance to the majority of the nation's uninsured. Approximately 23 million uninsured individuals, or two-thirds of the total, are employed or are the dependents of uninsured workers.

CCD supports a federal mandate requiring all employers to sponsor comprehensive and affordable health insurance programs for workers and their families, regardless of pre-existing conditions. The basic health benefits required under such a plan should include comprehensive health, personal, and support services, including but not limited to all hospital services, rehabilitation, mental health and counseling, long-term care, individual and family support services, prevention services (prenatal and well-baby care) and protection against catastrophic illness. Implementation of this program should not preclude existing state coverage mandates. **CCD urges the Commission to recommend that employers be required to provide comprehensive health insurance for part-time and full-time workers and their dependents.**

CCD believes that a federal mandate requiring employers to provide comprehensive health insurance for employees and their dependents must cover employers who are self-insured. According to the American Medical Care and

Review Association, between 52 and 58 percent of companies self-insure. These plans comprise approximately one-quarter of the group health insurance market.[17]

Millions of American workers are employed by companies that self-insure. Failure to bring these employers under a federal mandate undermines efforts to establish a national baseline for universal access to health care. This action is especially important to persons with disabilities who, as a group, strive to significantly increase participation in the workforce.

The Employee Retirement Income Security Act (ERISA) was enacted in 1974 to allow employers who self-insure to avoid the requirements of state insurance law and regulation. Essentially, self-insurance means that employers assume the risk of paying health insurance claims instead of paying premiums to an insurance company that has agreed to take the risk.

A provision in ERISA permits federal law to preempt state laws, insofar as such laws relate to benefit plans covered under ERISA. Under ERISA, self-insured plans need not comply with any of the state laws that require health insurance contracts to include specified benefits, comply with anti-discrimination standards applicable to insured plans, pay state insurance premium taxes, or participate in insurance pools for high-risk individuals.

For persons with disabilities, ERISA is a large and potentially dangerous loophole through which big companies can pass to avoid offering comprehensive benefits, such as those defined under a federal mandate. ERISA contains no minimum standards for health insurance plans.

CCD urges the Commission to extend employer-sponsored health benefit requirements to self-insured companies currently protected under ERISA.

On a related topic, CCD is concerned that many corporations are seeking to scale back employee health benefits to contain costs. Coverage for benefits is being discontinued and cost-sharing is being increased.

A recently issued report of the Service Employees International Union (SEIU) revealed that a sharp escalation in health care costs has resulted in a large increase in employee payments for health protection, a particularly troublesome development for low-wage workers.[18] Although technically insured, more than one-third of the disposable income of low-wage workers would be required for premium contributions and deductibles, expenses which must be paid before insurance coverage provides protection.

PUBLIC HEALTH INSURANCE

For many people with disabilities, publicly funded programs offer the best and, sometimes, only source of health insurance coverage. Medicare, Medicaid and military health programs (CHAMPUS and CHAMPVA) are the largest public programs offering health insurance to persons with disabilities.

MEDICARE

Over 95 percent of persons with disabilities over 65 years of age are Medicare beneficiaries, along with three million people of working-age who qualify on the basis of disability. Approximately 2.2 percent of beneficiaries with disabilities participate in Medicare because they are eligible for the End Stage Renal Disease (ESRD) program. This latter group represents the only disease-specific entitlement in Medicare and covers all age groups, including children.[19]

The Medicare program employs eligibility criteria which deny participation to many persons with disabilities. At age 65, essentially all Americans are eligible for Medicare coverage. Adults between the ages of 18 to 64 years of age can be eligible for Medicare if they become disabled after they have contributed to Social Security for a certain period or if they are dependents of Social Security beneficiaries who are retired, disabled, or deceased. Children under 18 are not eligible for Medicare, unless they qualify under the ESRD program. CCD believes that program eligibility should not be triggered by age and/or resources, but by ability to perform activities of daily living, mobility, and communication.

Medicare reimbursement strongly favors acute care over less intensive, ongoing and maintenance services. Consequently, elderly individuals and people with disabilities receiving Medicare benefits often find that the services they need most, such as extended home health services, respite care, nursing home care, outpatient and nonprescription drugs, and disposable supplies are nonreimbursable and, thus, mostly unavailable.

Medicare also applies restrictive reimbursement limits on a range of services. For example, Medicare beneficiaries with mental illness confront a $1,100 limit on reimbursement for outpatient mental health services, other than drug monitoring, and a lifetime limit of 190 days for psychiatric hospital care. Individuals who are disabled by mental illness and who qualify for Medicare through their SSDI status often discover that they cannot receive the medical care they need for the treatment of their disabling condition.[20]

CCD urges the Commission to recommend expanded Medicare coverage for comprehensive health, personal, and support services, including, but not limited to, rehabilitation, habilitation, mental health and counseling services, personal care, drugs, supplies, assistive devices, respite care, and extended care in home, community and institutional settings.

CCD strongly objects to the two year Medicare waiting period for Social Security Disability Insurance (SSDI) beneficiaries. This requirement deprives beneficiaries with disabilities of access to needed care, particularly during the early, critical months when prompt treatment is most effective in restoring functional ability. Moreover, for many beneficiaries the waiting period is not limited to two years, but is often 29 months or longer.

CCD urges the Commission to recommend that, within ten years, the two year waiting period for individuals qualifying for Medicare on the basis of disability be incrementally phased out.

MEDICAID

Medicaid is the largest provider of health care to low-income Americans under 65 years of age who are not covered by private insurance. Eligibility for Medicaid benefits is linked to eligibility for Aid to Families with Dependent

Children (AFDC) and Supplemental Security Income (SSI).

Medicaid is the primary insurer of children with disabilities, covering almost 23 percent of this population. Approximately 14 percent of working-age people with disabilities and 12 percent of elderly persons with disabilities are covered by the program.[21]

The concern heard most often about the Medicaid program pertains to its wide variation across the country. With the exception of a core set of mandated services, states are free to pick among the wide range of federal optional services, set the "amount, duration, and scope" of all services, and determine the rate of reimbursement for all services. As a result, massive inequities in levels of service exist among states, reflecting differences in fiscal capability and philosophy towards serving persons with low incomes.

CCD urges the Commission to recommend expansion of the mandatory service category under Medicaid to ensure access to comprehensive services, including, but not limited to rehabilitation, habilitation, mental health and counseling services, personal care, drugs, supplies, assistive devices, respite care, and extended care in home, community, and institutional settings.

Implementation of a federal mandate making Medicaid services comprehensive and uniformly available across the country would enhance the viability of using the program as a vehicle for improving access to health care for many uninsured persons and small employers.

CCD urges the Commission to promote a buy-in program to allow low-income persons, small employers, and individuals with pre-exisiting conditions to purchase Medicaid coverage at income adjusted rates.

A mandate for comprehensive services, is just one of several important Medicaid improvements CCD asks the Commission to endorse. The following proposals for Medicaid revision would also have an immediate and favorable impact on the program's ability to serve people with disabilities and foster its future value to a universal system of health care delivery.

Of major concern to disability advocates, including CCD, are the inherent biases within Medicaid which restrict sites of service delivery. For the past several decades, public policies concerning persons with disabilities have promoted consumer choice, maximum personal independence, and meaningful community integration. Unfortunately, Medicaid - which is the dominant federal funding source to states for services and programs for people with disabilities - has failed to keep pace with this movement.

The nation's sad legacy of providing long-term care in large institutional settings lingers today as a strong influence in the Medicaid program, impeding the ability of people with disabilities and their families to receive services at home or in less restrictive, community settings. The Medicaid Intermediate Care Facilities for the Mentally Retarded and Related Conditions (ICF/MR) program is the primary source of federal involvement in providing long-term care services to persons with mental retardation and other developmental disabilities. Many individuals and their families want Medicaid services that are far less extensive than those offered under the traditional ICF/MR 24-hour model of care. They are looking toward a goal of maximizing economic and personal independence and capability, with the fewest restrictions on individual liberty and rights. To do this, they need access to comprehensive services, including family support services, to assist in maintaining family members with developmental disabilities at home. Without such services, many families have no alternative but to use 24-hour, out-of-home, facility-based care.

CCD urges the Commission to recommend the elimination of Medicaid's institutional bias, so that all states provide access to comprehensive health, personal, and support services in all home and community settings.

CCD is also concerned that Medicaid eligibility is unduly restrictive, particularly for individuals who rely on technology to survive, and pregnant women and children. CCD is encouraged that Congress took up some of these issues in the "Omnibus Budget Reconciliation Act of 1989 (OBRA)." However, even in such instances, there remains the need for appropriate implementation and further reform.

CCD believes that Medicaid eligibility should be extended to all individuals whose lives depend on assistive technologies. In 1982, the much publicized case involving Katie Beckett resulted in Medicaid reforms allowing states to pay for certain in-home care for children dependent on medical technology, when similar hospital-based care would be more expensive. As of March, 1988, twenty-one states and the District of Columbia had elected this option and offered in-home care to qualified children with disabilities on a statewide basis.[22] States may provide similar coverage under Medicaid home and community-based services waivers approved by the Secretary of Health and Human Services. These reforms, although commendable, do not effectively address the level or scope of need among children and adults who rely on assistive technologies.

CCD urges the Commission to recommend that Medicaid eligibility be mandated for children and adults who are technology-dependent living in home and community settings, regardless of family income or perceived risk of institutionalization.

CCD is pleased that Congress took a significant step in improving Medicaid effectiveness by extending Medicaid coverage to pregnant women and children up to age six with incomes below 133 percent of poverty. CCD believes that eligibility for Medicaid services should be further expanded to include pregnant women and children up to 185 percent of the poverty level, with coverage for women continuing for up to 60 days after delivery. Coverage should initially be extended to all children up to six years of age, in families living below 100 percent of the poverty level, with an extension of coverage to be phased-in with these children until they reach age 18 years of age.

CCD considers the Medicaid Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT) program a valuable point of access for needed health care for children with disabilities. The EPSDT program is designed to assure access to services, including physical examinations; immunizations; vision, hearing and laboratory tests; and, dental screening, and treatment necessary to correct or ameliorate any discovered physical or mental health problem. States have the option of providing a range of other services under EPSDT, including assistive devices, and must conduct outreach activities which link Medicaid-eligible children to service providers.

CCD was extremely pleased, therefore, that Congress strengthened the EPSDT program in provisions included in OBRA. Beginning April 1, 1990, the EPSDT program will be required to serve children with disabilities under age 21 and treat any physical or mental problem uncovered in screening, whether or not such treatment is part of the state's regular Medicaid package of benefits.

CCD urges the Commission to consider further expansion of the extent and scope of the EPSDT program, to ensure access to comprehensive, nationally uniform services to all eligible children, and to promote the prompt and thorough implementation of 1989 OBRA revisions to EPSDT requirements.

Access to Medicaid services is increasingly threatened by the dwindling number of practitioners willing to accept the low reimbursement rates set by Medicaid. A 1987 GAO study of Medicaid reimbursement rates found that the maximum allowable physician fees for a brief office visit to a general practitioner ranged from an average of $6.00 in New Hampshire to $28.41 in Alaska for 1986.[23] Physicians and other health practitioners cannot be expected to provide quality services for payment that is grossly inadequate. This is particularly true for Medicaid, which, in many states, has a reputation for being overly bureaucratic and slow to pay. CCD urges the Commission to recommend increased payment for Medicaid services, commensurate with quality and difficulty of care.

MILITARY AND VETERANS' HEALTH PROGRAMS

Health care programs serving military personnel, veterans and their families represent a signficant component in the nation's health care delivery system. Approximately eight percent of persons with disabilities receive health care and related services under military and veterans' programs, including CHAMPUS and CHAMPVA.

CCD urges the Commission to recognize the value, need, and reciprocal impact of military and veterans' health programs in efforts to improve access to health care.

DRUGS AND SUPPLIES

Access to essential drugs, biologicals, medical foods, and disposable supplies is vitally important to many persons with disabilities. Much of the progress associated with increased survivability of individuals with severe chronic conditions has occurred because of the development of new drugs, biologicals and medical foods. Many people with severe chronic conditions rely on the daily use of essential drugs to maintain their bodily functioning, ameliorate the effects of their disabilities, and prevent medical complications. Similarly, many people with disabilities must use disposable supplies on a routine basis to care for disabling impairments and to treat chronic diseases.

Unfortunately, the availability and adequacy of health insurance coverage fo essential drugs and supplies does not reflect the value of these products to persons with disabilities. There is substantial variation among public and private programs as to whether or not insurers will pay for drugs and supplies. CCD believes these limitations constitute a serious impediment to the health and independence of people with disabilities.

In general, insurers will pay for prescription drugs administered in a medical setting, such as a hospital or nursing home. Some insurers, however, will not cover these same drugs in outpatient settings. Medicare, for example, does not cover outpatient prescription drugs that can be self-administered by a beneficiary, with the exception of immunosuppressive drugs needed by an organ transplant recipient.

It should be noted that 5.5 million Medicare enrollees, representing about 17 percent of program participants, incur more than $500 per year in prescription drug costs. The average annual drug expense is nearly $1,000 for beneficiaries with prescription drug expenditures in excess of $500. Less than half of all elderly persons have some form of insurance or financial assistance to help with the costs of these drugs, and even those with such protections, commonly find that payments do not completely cover costs.[24]

Restrictions on payment based on the setting of care exact a high toll from Medicare enrollees, including the nearly three million persons who qualify on the basis of disability. Beneficiaries are forced to either bear the brunt of high out-of-pocket costs for outpatient drugs or to jeopardize their health by cutting dosages or going without the drugs they need.

Inconsistencies in coverage policies also create access problems. For example, virtually every state Medicaid program offers coverage for prescription drugs, in compliance with regulations establishing aggregate limits on payments for multiple source drugs (those for which therapeutic equivalents or "generic" versions are available) and all other drugs. However, thirty-two states have set their own limits for at least some drugs.[25] This inconsistency, under public and private plans, is confusing to consumers, who must negotiate a maze of coverage policies, payment systems, and contradictory instructions simply to obtain the medications they need.

Many private health insurers choose to limit payment for prescription drugs. Insurers will generally refuse to pay for drugs which have not been officially approved for a specific health condition by the Food and Drug Administration. This can create a problem for persons with rare disorders, who may need an experimental drug. Insurers have also used coverage exclusions for drugs as a means to discourage individuals perceived to have higher health risks from participation in insurance programs. A recent example concerns AZT, one of the few drugs approved for the treatment of HIV infection. It appears that some insurers are excluding payment for AZT, as part of a strategy to discourage persons perceived to be "at-risk" of HIV infection from participating in their health insurance plans.

CCD finds that problems associated with insurance coverage for prescription drugs are even more acute in the area of over-the-counter, nonprescription drugs.

Many health insurers will only pay for drugs which are medically prescribed, thus eliminating many essential drugs used by individuals with chronic conditions. Among these drugs commonly excluded from coverage are such basic items as insulin, pain medication, muscle relaxants, and vitamins. These drugs can control seizures for persons with epilepsy, enable people with diabetes to metabolize food, and can help others by preventing infection, reducing pain, relaxing spastic muscles, lowering blood pressure, and avoiding depression.

For someone with diabetes, who depends on insulin to survive, exclusion of payment for insulin translates into a lifelong, unrelieved drain on personal financial resources.

CCD believes that the lack of payment for disposable supplies diminishes the ability of people with disabilities to pursue healthful, independent lives. Such supplies, including colostomy supplies, diabetic testing supplies, catheters, dressings, and supplies for incontinence, are necessitated by many health conditions and play an important role in the prevention of primary and secondary disabilities. The use of these supplies, especially on a daily basis, can be expensive, ranging from several hundred to several thousand dollars annually.[26] People with disabilities and their families generally struggle to meet the costs of necessary supplies unassisted, since most insurance programs exclude coverage for supplies.

CCD strongly believes that the burden of cost associated with prescription drugs, other drugs, including insulin, biologicals, medical foods, and supplies should be minimized to assure access for people with disabilities.

To this end, CCD urges the Commission to improve private and public coverage for drugs and supplies through its recommendations to Congress.

ASSISTIVE TECHNOLOGY AND RELATED SERVICES

During the past decade, dramatic advances in the development of assistive technology have occurred which can substantially improve the quality of life for individuals with disabilities. Unfortunately, private and public health insurance systems have not kept pace with these rapidly developing technologies. Limitations on coverage and payment have denied millions of Americans access to assistive devices and related services that would otherwise allow them to become gainfully employed, become self-sufficient citizens, or to generally enhance their quality of life.[27]

For the purpose of this statement, the term "assistive devices" refers to devices designed for and used by individuals to eliminate, ameliorate, or compensate for one or more developmental or functional limitations. Successful use of assistive devices depends on special services, including rehabilitation engineering, physical and occupational therapy, speech-language pathology, and audiology. Devices and related services vary greatly in their level of technical sophistication, purpose and cost.[28]

Most private insurance plans do not explicitly include or exclude coverage of assistive technology in their benefits. Their medically-oriented coverage policies frequently fail to include access to assistive devices, which are considered rehabilitative in nature. In addition, private insurers rely heavily on physicians to determine which services are reimbursable and many physicians are simply unfamiliar with the range of assistive devices that would benefit individuals with disabilities. As a result, claims for assistive technologies submitted to private insurance companies are often denied.

Coverage for assistive devices under public health insurance programs is equally problemmatic. Medicare will reimburse for assistive devices that are considered durable medical equipment or which replace all or part of a body organ or function.

Durable medical equipment is defined as "equipment which (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) generally is not useful to a person in the absence of illness or injury; and (d) is appropriate for use in the home." To obtain reimbursement for DME under Medicare Part B, all of the above criteria must be met.

Medicare will also pay for a prosthetic device (other than dental) when it replaces all or part of an internal body organ, or replaces all or part of the function of a permanently inoperative or malfunctioning internal body organ. Medicare also provides coverage for services related to the replacement or repair of the device.

In practice, serious inequities exist under Medicare which limit beneficiary access to appropriate assistive devices and related services. For example, Medicare does not classify augmentative communication aids as durable medical equipment (DME) or prosthetic devices. Although many readily available communication devices would clearly enhance the ability to function in a job or at home for a person without functional speech, Medicare denies coverage for these devices because they are considered "convenience" items that are not medical in nature and do not replace an internal body organ.

Medicaid allows states the option of covering DME, prosthetic devices and rehabilitation services. Unfortunately, because such coverage is optional, many states do not include coverage for assistive devices in the Medicaid programs, placing low-income persons with disabilities in these states at a significant disadvantage. States also limit the availability of rehabilitation services associated with the devices that are desperately needed by children with disabilities.

Medicaid payment for a limited number of assistive devices is available under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. States are required to "provide health care, treatment, and other measures to correct or ameliorate any defects and chronic conditions discovered," such as treatment for "defects in vision and hearing," which includes eyeglasses and hearing aids. Unfortunately, EPSDT eligibility is limited to children under the age of 21 and anyone older is denied this avenue of access to needed assistive technologies and services.

CCD believes that coverage for assistive devices and related services is vitally important to people with disabilities. Payment for assistive technology includes: costs necessary to purchase the assistive device, regardless of sophistication; services required to support the use of an assistive device, including identification, assessment, training, and case management activities; and, necessary adaptation, customization, maintenance, repair, and replacement costs.

CCD urges the Commission to include in its recommendations mechanisms to improve private and public coverage for assistive devices and related services, including assessment, adaptation, training, and follow-up services.

FINANCING

Universal participation in a national health care system offering comprehensive, appropriate, and affordable coverage of health, personal, and support services will not be inexpensive. However, the cost to society of perpetuating the current system is far greater. The nation's 43 million American citizens with disabilities and their families are willing to contribute their fair share to improve existing health programs and promote implementation of a truly complete and effective universal national health system.

In 1989, the 2.9 percent payroll tax for Medicare Hospital Insurance (Part A) was only applied to the first $48,000 of earned income, enabling high wage earners to pay a lower rate of their total earnings to support the program. According to the Congressional Budget Office, uncapping the amount of income subject to the Medicare tax would generate an additional $7.1 billion in 1990, rising to $9 billion in 1993.[29] Eliminating the cap would affect approximately five percent of wage earners.

At a minimum, CCD supports the elimination of the cap on personal income subject to the Medicare tax to generate funds for improved coverage of health, personal, and support services,

particularly in the area of long-term care.

CCD urges the Commission to include in its recommendations the establishment of an equitable financing scheme that is capable of improving coverage of existing health insurance programs and, ultimately, of providing for universal participation in a comprehensive national health system, including cost-sharing on the part of persons with disabilities and their families that is equal to that of their nondisabled peers.

RELATED EFFORTS AFFECTING HEALTH CARE ACCESS

The Commission is charged with making recommendations to Congress respecting federal programs, policies, and financing needed to assure the availability of comprehensive health care, including long-term care, for all Americans. The successful implementation of these recommendations, particularly as they relate to improved access to health care for people with disabilities, cannot be accomplished unless other, related efforts are taken into account.

CCD requests that the Commission consider the important role of disability prevention and health promotion activities, supply of health care personnel, and dat collection and analysis on access to health care for people with disabilities.

DISABILITY PREVENTION AND HEALTH PROMOTION

The nation's health care delivery system must not be reformed without also significantly expanding federal prevention and health promotion efforts. Health promotion and disability prevention programs make good social and economic sense.

Childhood immunizations, for example, are an effective means of disease prevention. However, between 1980 and 1985 there was a decline in the immunization rates among two-year-olds for polio, DPT, measles, rubella, and mumps. Overall, only 60 percent of children under four years of age have received the complete basic set of immunizations. Not surprisingly, the incidence of preventable disease has risen, consistent with the drop in immunizations. Cost is cited as a major justification for decreasing immunizations, although a 1985 study found that each dollar spent on childhood immunizations saves more than $10 later.[30]

More than 50,000 babies are born annually with alcohol-related impairments. In about one-fourth of these cases, the disability, including facial deformity, heart abnormality, and mental retardation, is severe enough to be classified as fetal alcohol syndrome (FAS). FAS is the greatest preventable cause of mental retardation. According to some researchers, FAS accounts for an estimated 20 percent of all cases of mental retardation.[31] Prevention, in the form of increased education, counselling and related services for pregnant women and their families, are needed to reduce the incidence of FAS and other alcohol-related disabilities.

Although many people with disabilities are not sick, they may have frail margins of health which must be protected by preventive services. Such services provide for early detection and treatment and, insodoing, avoid unnecessary complications. According to the National Council on Disability, the prevention of primary and secondary disabilities could substantially reduce the costs of disability and health care for Americans, reduce federal spending for disability in the near future, and decrease the incidence of disability for future generations.[32] Many persons with disabilities are at greater risk of incurring secondary disabilities, relating directly and indirectly to their primary disabling conditions. Access to appropriate prevention and health promotion services significantly increases opportunities to avoid or minimize the incidence of secondary impairments.

CCD urges the Commission to support, in its recommendations, health promotion and disability prevention efforts, including services which prevent primary and secondary disabilities.

SHORTAGE OF HEALTH CARE PERSONNEL

For the past several years, access to health care for all Americans, including people with disabilities, has suffered because demand for service consistently outstrips the supply of qualified care providers. The shortage of health professionals, perhaps most acute in rural areas, plagues all sectors of the health delivery system.

Access to hospital care is threatened by personnel shortages, according to a 1989 American Hospital survey. Despite adding overtime, changing compensation programs, setting up on-call staff pools and using contract services, one-fourth of hospitals responding to the survey were forced to cut services, more than 15 percen closed beds or units and almost 13 percent sent patients to other hospitals because they lacked sufficient staff.[33]

Nationwide, rehabilitation facilities report chronic job vacancies for allied health professionals, such as physical and occupational therapists. Persons seeking care at these centers often end up on long waiting lists.

Unfortunately, this situation is only expected to get worse. According to a 1988 Institute of Medicine study, the demand for physical therapists and occupational therapists will increase by 87 percent and 52 percent, respectively, far outstripping supply.[34] Shortage estimates for other professions, including respiratory therapists, speech-language pathologists, audiologists, rehabilitation counselors, psychologists, psychiatric social workers, and laboratory technicians, are as dramatic.

CCD is equally concerned about shortages of personnel whose services, though not specifically health care in nature, contribute to the well-being and independence of people with disabilities. For example, a recent study by the American Foundation for the Blind reveals that demand for orientation and mobility services is reaching new highs, while the supply of trained instructors is dwindling. Orientation and mobility training involves teaching people with visual impairments to travel safely and efficiently. Its importance to visually impaired individuals goes beyond independent travel, to include personal dignity and the ability to particpate fully in society. An inadequate supply of orientation and mobility instructors directly impinges on the independence of persons with visual impairments.[35]

CCD is also concerned about the systemic shortage of support personnel who assist people with disabilities in facilities, at home and in community settings. These individuals, including personal care attendants, home health aids, interpretors, and mobility assistants, are needed to provide services critical to the health and independence of persons with disabilities.

CCD urges the Commission to support increased funding for education and related programs to increase the supply of qualified health care professionals and other personnel, including funding for scholarships for preservice and inservice training, and faculty development.

IMPROVED DATA COLLECTION AND ANALYSIS

National data is insufficient to adequately assess the health care needs and patterns of utilization of health care and related services for people with disabilities. Indicators that reflect specific disabilities must be incorporated in current data collection and analysis efforts to ensure that decisions affecting access to care for persons with disabilities are sound.

CCD urges the Commission to include in its recommendations methods to improve the collection and analysis of data concerning health care and people with disabilities, including utilization, adequacy of coverage, cost of coverage and care, and prevention.

CONCLUSION

The Pepper Commission has a unique opportunity to shape the nation's health care delivery system to better serve all Americans, including people with disabilities. Universal access to comprehensive, appropriate, and affordable health, personal, and support services is an essential step toward maximizing the physical and mental abilities of people with disabilities and promoting their independence and integration into the mainstream of community life. CCD urges the Commission to attend to the needs of persons with disabilities and their families in making recommendations to Congress.

CCD sincerely hopes that this statement is useful to Commission members and staff. Thank you.

Please contact Ms. Kathy McGinley, Co-chair of the CCD Health Task Force, with questions or requests for additional information. Ms. McGinley can be reached at the Association for Retarded Citizens, 1522 K Street, N.W., Washington, D.C. 20005; telephone 785-3388.

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Consortium for Citizens with Disabilities

TASK FORCE ON HEALTH

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April 9, 1990

The Honorable John D. Rockefeller, IV
Chairman
The Pepper Commission
140 Cannon House Office Building
Washington, D.C. 20515

Dear Mr. Chairman:

I am writing to provide you with information on people with disabilities who are unemployed. This letter is in response to a question you asked of Mr. Steve Monson on October 24, 1989. Mr. Monson appeared before the Commission on behalf of the Consortium for Citizens with Disabilities.

Specifically, you asked for a breakdown by type of disability of the population of persons with disabilities who are unemployed. Unfortunately, this exact data is not being collected. However, data is available which describes, by type of disability, conditions which limit or preclude an individual's ability to work.

Information drawn from the National Health Interview Survey (see enclosed materials from the 1989 "Chartbook on Disability in the United States") shows the top five chronic health conditions causing work limitation. These are heart disease, arthritis, spinal curvature and other back impairments, intervertebral disk disorders, and impairments of the lower extremities.

Information is also provided in the Chartbook (see enclosed) on persons helped by the Vocational Rehabilitation system, which serves persons with disabilities needing assistance in obtaining employment. Of the 219,616 persons who successfully completed their rehabilitation program and found work, 21.7% had orthopedic impairments, 17.8% had mental illness, 12.9% had mental retardation, 7.1% had alcoholism, 8.2% were deaf or hard of hearing, and 8.5% were blind or had other visual impairments. This information offers some insight into the types of major disabling conditions which affect employment and their level of occurrence in the population.

A table prepared by the Disability Statistics Program (see Table 2, enclosed) provides a detailed look at selected chronic conditions causing limitation in work by nature of limitation and age. This data is very helpful in understanding the impact of different types of chronic conditions on work and other life activities.

I have also included materials describing employment and individuals with disabilities taken from the 1986 "International Center for the Disabled Survey of Disabled Americans."

I hope that this information is helpful. Your interest in improving access to health care for people with disabilities and their families is greatly appreciated. The Consortium for Citizens with Disabilities is ready to work with you and Pepper Commission staff to continue to develop and implement policies to reform the nation's health care delivery system.

On behalf of the Consortium and persons with disabilities, thank you for your attention to our concerns.

Sincerely,

Randall L. Rutta

Randall L. Rutta
Member, Task Force on Health

Disability Statistics Report

A Publication of the Disability Statistics Program

Number 2 • November 1989

Disability Risks of Chronic Illnesses and Impairments

Mitchell P. LaPlante

Introduction

Disability is a limitation, caused by one or more chronic physical or mental health conditions, in performing activities that people of a particular age are generally expected to be able to perform (Haber, 1967; Nagi, 1976). Such activities consist of roles and role-related activities,[1] the major types being play for infants, attending school for children, working at a job or keeping a home for working-age adults, and carrying out basic life activities necessary to live independently for all mature persons.

Disability risk refers to the likelihood that a chronic illness or impairment causes disability. Chronic conditions are by definition antecedents of disability, but they vary considerably in disability risk. Knowledge of the comparative disability risks of chronic conditions is important in understanding the origins of disability, yet little systematic research exists on this subject, especially at the national level.

In order to compare fairly disability risks of various chronic conditions, several factors that influence disability risk must be taken into account. From the clinical perspective, chronic health conditions differ in degree of functional limitation, prognosis, course of treatment and management, and rehabilitative potential, all of which are related to disability. In addition, disability is influenced greatly by the demands, expectations, and resources of the social and physical environments.

Populations defined by the presence of specific health conditions often differ in demographic and environmental characteristics. For example, widespread evidence exists that numerous chronic physical health conditions are distributed more frequently among persons of lower than higher social class (for a review, see Dutton, 1986). Some chronic conditions are more highly associated than other conditions with lower social class. Since persons of lower social class are also more likely to have a disability, social class must be taken into account in order to compare disability risks of various conditions. Social class is an illustration; a variety of biologic, individual, and environmental factors must be assessed to develop an understanding of disability risks of chronic health conditions.

We can separate factors influencing the risk of disability into two classes: those intrinsic to health conditions and those related to the characteristics of the individual and the social and physical environments. To compare fairly disability risks of specific chronic conditions, it is desirable to identify risks that are intrinsic to each condition, what may be viewed as part of the "natural history" of a condition. However, the identification of risks truly intrinsic to health conditions remains an elusive goal. Risks of disability estimated for various chronic conditions will subsume, in addition to the intrinsic risks of the conditions, all the effects of nonintrinsic factors that remain uncontrolled. Measures of sociodemographic characteristics can be controlled statistically to provide an adjustment to better approximate intrinsic disability risks of chronic conditions.

Comparative data on disability risks of specific chronic illnesses and impairments have manifold uses:

1) Disability is an important measure of the consequences of chronic health conditions in the lives of individuals. Comparison of risks of disability of various conditions provides one index of their social importance.

2) Information on disability risks for various conditions has direct use in health and social policy. Knowledge of disability risks of chronic health conditions can be useful in designing services for prevention, treatment, management, rehabilitation, and social assistance. Conditions that usually result in particularly severe disability often require intensive acute and long-term medical and social services and generate high demand for social assistance.

3) Combined with knowledge of the prevalence of conditions and methods to prevent disability from them, information on disability risks can be useful in prioritizing interventions to reduce disability.

4) Information on disability risks of specific health conditions can also be useful in designing data systems to estimate the prevalence and social burden of chronic conditions in populations. It is often neither possible nor desirable to enumerate the prevalence of all chronic health conditions in the population. However, conditions with high disability risks, or otherwise high social burden, should be identified for the reasons stated above.

This report provides results from an investigation of the comparative disability risks of specific chronic physical and

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[1] This definition differs from the ICIDH schema (World Health Organization, 1980), as noted by Granger (1984).

Prepared under a cooperative agreement (No. G0087C2014) between the National Institute on Disability and Rehabilitation Research and the Institute for Health & Aging. An earlier version of this report was presented at the Annual Meeting of the Society for Disability Studies, June, 1988. The author wishes to thank H. Stephen Kaye and Ida VSW Red for editorial assistance, Norton S. Twite for typing assistance, and Scott D. Hood for assistance in preparation of tables. Interpretations and conclusions are those of the author and do not necessarily reflect the views of the respective Institutes. For reprints, contact Mitchell P. LaPlante, Ph.D., Director, Disability Statistics Program, Institute for Health & Aging, N531Y, University of California, San Francisco, CA 94143-0612

TABLE 2. Percent of Selected Chronic Conditions Causing Limitation in Work by Nature of Limitation and Age: United States, 1983-1996 (Four-Year Average)

	Ages 18-69				*Ages 18-44*				*Ages 45-69*			
		Percent Causing				*Percent Causing*				*Percent Causing*		
Chronic Condition	*Number of Conditions (1,000s)*	*Any Work Limitation*	*Inability to Work*	*Need for Help in Basic Life Activities†*	*Number of Conditions (1,000s)*	*Any Work Limitation*	*Inability to Work*	*Need for Help in Basic Life Activities†*	*Number of Conditions (1,000s)*	*Any Work Limitation*	*Inability to Work*	*Need for Help in Basic Life Activities†*
All selected chronic conditions	286,710	8.6	5.4	1.3	139,267	4.7	2.0	0.6	147,443	12.3	8.6	2.0
Skin and musculoskeletal												
Rheumatoid arthritis	969	40.1	26.5	9.7	252	34.8	15.1 *	1.5 *	716	41.9	30.5	12.6
Osteoarthritis/other arthropathies	20,725	14.3	9.5	2.3	4,813	7.0	3.0	0.9 *	15,913	16.5	11.4	2.8
Intervertebral disk disorders	3,616	40.7	19.1	4.6	1,659	37.8	11.5	3.9	1,957	43.2	25.4	5.1
Osteomyelitis/bone disorders	2,308	14.1	8.9	2.9	948	10.3	5.4 *	0.8 *	1,360	16.8	11.3	4.3 *
Bursitis	3,904	4.3	2.7	0.6 *	1,465	3.0 *	1.3 *	0.0	2,438	5.1	3.4	1.0 *
Psoriasis and dermatitis	7,837	1.4	0.5 *	0.0	5,090	0.9 *	0.2 *	0.0	2,747	2.2	1.2 *	0.1 *
Skin cancer	988	1.8 *	0.0	0.6 *	206	0.0	0.0	0.0	782	2.3 *	0.0	0.7 *
Other selected skin and musculoskeletal	20,476	1.7	1.1	0.1 *	11,228	0.4 *	0.1 *	0.0	9,248	3.2	2.2	0.3 *
Total	60,823	9.5	5.7	1.4	25,661	5.0	1.8	0.5	35,161	12.8	8.5	2.1
Impairments												
Absence of arm(s)/hand(s)	64	51.6	18.0 *	5.4 *	17 *	82.7 *	0.0	0.0	46 *	39.8 *	24.8 *	7.4 *
Absence of leg(s)	207	72.9	54.9	32.7	59 *	71.2 *	23.7 *	24.7 *	148	73.5	67.3	35.8
Absence of fingers, toes, feet	1,416	5.4	2.8 *	1.1 *	605	4.8 *	2.7 *	0.0	811	5.8 *	2.9 *	1.9 *
Other absence	730	17.1	12.0	2.8 *	301	16.3 *	11.0 *	3.4 *	428	17.7	12.7	2.4 *
Complete paralysis in extremity	421	50.8	39.8	21.9	133	65.8	38.2	35.6	288	43.9	40.6	15.6 *
Cerebral palsy	157	58.2	46.7	28.0 *	134	55.7	46.3	29.8 *	23 *	72.9 *	49.2 *	17.2 *
Partial paralysis in extremity	336	55.0	46.6	22.2	94	64.0	37.0 *	7.4 *	242	51.5	50.3	28.0
Paralysis in other sites (complete/partial)	196	42.0	24.1	9.5 *	64	36.9 *	16.4 *	15.9 *	132	44.4	27.8 *	6.5 *
Curvature of back or spine	3,472	13.4	6.3	1.3 *	2,242	11.5	3.9	0.8 *	1,230	16.8	10.7	2.2 *
Other orthopedic impairment of back	8,703	21.3	8.9	2.2	5,087	16.4	5.4	1.0 *	3,617	28.2	13.9	4.0
Orthopedic impairment in upper extremity	2,491	19.8	10.2	1.9 *	1,356	18.1	7.5	0.9 *	1,135	21.9	13.3	3.0 *
Orthopedic impairment in lower extremity	8,166	15.8	7.9	2.0	4,648	11.9	4.6	0.8 *	3,518	20.9	12.2	3.5
Other orthopedic impairments	247	39.5	23.3	7.9 *	133	37.6	19.1 *	0.0	114	41.9	28.3 *	17.2 *
Speech impairment	1,186	11.2	7.6	3.3 *	701	10.1	5.6 *	3.0 *	484	12.7	10.5 *	3.7 *
Blind in both eyes	180	71.9	58.6	26.7	76	63.2	48.6	8.8 *	105	78.2	65.9	39.7
Cataracts	1,784	8.4	5.6	1.8 *	207	9.2 *	1.4 *	0.0	1,577	8.3	6.1	2.0 *
Glaucoma	853	9.4	8.6	2.1 *	158	5.5 *	3.7 *	1.6 *	695	10.3	9.8	2.2 *
Other visual impairment/retinal disorders	5,766	8.3	5.4	1.6	2,993	4.7	1.6 *	0.4 *	2,773	12.2	9.4	2.8
Deaf in both ears	868	15.8	8.2	1.7 *	235	21.7	13.2 *	3.1 *	633	13.7	6.4 *	1.2 *
Other hearing impairments	12,979	2.2	1.2	0.2 *	4,832	2.4	0.6 *	0.1 *	8,146	2.1	1.5	0.2 *
Mental retardation	520	75.3	53.1	37.4	393	75.9	48.0	37.9	127	73.6	69.0	36.1
Other selected impairments	906	12.3	6.8	2.7 *	364	8.5 *	2.6 *	0.8 *	542	14.8	9.7 *	4.1 *
Total	51,648	13.7	7.5	2.5	24,832	12.5	5.3	1.8	26,814	14.7	9.6	3.1
Digestive												
Ulcers	3,843	8.0	6.4	0.7 *	1,977	3.1	2.2 *	0.0	1,866	13.2	10.8	1.5 *
Abdominal hernia	3,299	9.8	5.3	1.0 *	922	6.0 *	0.9 *	0.0	2,377	11.2	7.0	1.4 *
Enteritis and colitis	1,772	5.8	3.3 *	0.5 *	983	4.4 *	2.1 *	0.0	789	7.5	4.8 *	1.8 *
Cancer of digestive sites	143	46.8	39.6	11.1 *	6 *	49.0 *	49.0 *	0.0	136	46.7	39.2	11.6 *
Other selected digestive disorders	15,138	2.8	1.9	0.2 *	7,394	1.3	0.8 *	0.0	7,744	4.1	3.0	0.5 *
Total	24,195	5.1	4.4	0.7	11,282	2.3	1.2	0.0	12,912	7.4	5.4	1.8

TABLE 2. Percent of Selected Chronic Conditions Causing Limitation in Work by Nature of Limitation and Age: United States, 1983-1986 (Four-Year Average), Cont.

	Ages 18-69				Ages 18-44				Ages 45-69			
		Percent Causing				Percent Causing				Percent Causing		
Chronic Condition	*Number of Conditions (1,000s)*	*Any Work Limitation*	*Inability to Work*	*Need for Help in Basic Life Activities†*	*Number of Conditions (1,000s)*	*Any Work Limitation*	*Inability to Work*	*Need for Help in Basic Life Activities†*	*Number of Conditions (1,000s)*	*Any Work Limitation*	*Inability to Work*	*Need for Help in Basic Life Activities†*
Circulatory												
Rheumatic fever	1,284	12.5	9.1	1.9 *	575	7.5 *	4.5 *	0.8 *	709	16.6	12.9	2.7 *
Ischemic heart disease	4,401	31.6	20.9	3.5	370	29.9	15.0	4.1 *	4,031	31.7	21.4	3.5
Heart rhythm disorders	4,893	5.3	3.7	0.5 *	2,540	2.1 *	1.1 *	0.3 *	2,353	8.8	6.4	0.8 *
Other heart disease/disorders	2,800	39.9	29.2	4.9	850	16.5	8.3	1.6 *	1,951	50.1	38.3	6.3
Hypertension	21,489	9.6	6.7	0.8	6,245	3.6	1.9	0.2 *	15,245	12.1	8.7	1.0
Cerebrovascular disease	1,334	32.5	28.1	14.1	173	14.4 *	10.7 *	4.2 *	1,161	35.2	30.8	15.6
Arteriosclerosis	1,395	12.0	9.7	1.9 *	48 *	5.9 *	0.0	0.0	1,347	12.2	10.0	2.0 *
Phlebitis, varicose veins	6,232	4.8	3.2	0.5 *	2,574	2.8	0.9 *	0.3 *	3,658	6.2	4.9	0.6 *
Other selected circulatory	9,796	2.3	1.8	0.4 *	5,245	0.5 *	0.3 *	0.1 *	4,551	4.3	3.5	0.8 *
Total	53,624	11.4	8.1	1.5	18,620	3.7	1.9	0.4	35,006	15.5	11.5	2.1
Respiratory												
Chronic bronchitis	6,553	2.9	1.7	0.3 *	3,815	0.9 *	0.4 *	0.1 *	2,738	5.6	3.4	0.6 *
Asthma	5,292	12.6	5.7	0.9 *	3,409	10.1	2.8	0.8 *	1,883	17.2	10.9	1.3 *
Hay fever	15,754	0.8	0.2 *	0.0	11,114	0.8	0.2 *	0.0	4,640	0.9 *	0.2 *	0.0 *
Sinusitis	25,779	0.3	0.1 *	0.0	16,079	0.1 *	0.0	0.0	9,699	0.5 *	0.3 *	0.1 *
Emphysema	1,399	38.7	28.1	7.0	116	14.2 *	11.6 *	5.9 *	1,283	40.9	29.6	7.1
Lung or bronchial cancer	99	72.7	69.9	17.6 *	15 *	73.1 *	73.1 *	20.3 *	84	72.7	69.4	17.1 *
Pneumoconiosis/asbestosis	252	35.9	34.7	2.9 *	82	0.0	0.0	0.0	169	53.3	51.5	4.3 *
Other selected respiratory	5,640	4.8	4.0	0.9 *	3,700	0.8 *	0.3 *	0.1 *	1,941	11.8	10.6	2.5 *
Total	60,768	3.3	2.0	0.4	38,330	1.4	0.4	0.1	22,437	6.6	4.8	0.9
Miscellaneous												
Diabetes	4,182	29.0	20.1	4.1	884	18.9	6.9	1.8 *	3,298	31.7	23.6	4.7
Anemias	2,427	2.8	1.8 *	0.0	1,642	1.2 *	0.8 *	0.0	785	6.1 *	3.9 *	0.0
Kidney disorders	2,735	7.5	5.5	1.4 *	1,468	3.1 *	1.5 *	0.0	1,267	12.6	10.3	3.0 *
Female genital disorders	5,473	2.5	0.8 *	0.1 *	4,066	1.3 *	0.3 *	0.0	1,406	5.9	2.4 *	0.2 *
Epilepsy	762	37.0	30.6	6.7 *	535	34.0	25.5	5.5 *	227	44.0	42.8	9.3 *
Multiple sclerosis	155	58.9	44.6	37.5	72	48.2	39.8 *	28.8 *	82	68.3	48.8	45.1
Migraine headache	6,990	2.0	1.1	0.2 *	4,879	1.7	0.8 *	0.2 *	2,111	2.5 *	1.9 *	0.3 *
Cancer of female breast	307	22.1	14.6 *	2.7 *	59 *	21.4 *	7.7 *	0.0	247	22.3	16.2 *	3.4 *
Cancer of genitourinary sites	234	29.3	28.3	1.7 *	109	7.1 *	7.1 *	3.5 *	125	48.8	46.8	0.0
Other selected miscellaneous	12,389	2.6	2.0	0.5	6,827	1.2	0.8 *	0.3 *	5,562	4.3	3.4	0.8 *
Total	35,654	7.3	5.1	1.2	20,541	3.3	1.8	0.5	15,110	12.6	9.5	2.1

* Figure has low statistical reliability or precision (relative standard error exceeds 30 percent).

† Includes Activities of Daily Living and Instrumental Activities of Daily Living.

Source: National Health Interview Survey, 1983-1986. Data are estimates based on household interviews of the civilian noninstitutionalized population.

Note: ICD and impairment codes are provided in Appendix B.

Chartbook on Disability in the United States

Prepared for:

U.S. Department of Education
Contract # HN 88011001
National Institute on Disability and Rehabilitation Research
Washington, DC

Lauro F. Cavazos, Secretary

March 1989

Section 5: Work and Disabilities

Attempting to count people who have a work disability is somewhat easier than trying to estimate the number of all people with disabilities. In work disability there is an easy-to-survey age group (the working ages-- 16-64 for one survey and 18-69 for another) and a specific activity in which to measure ability (namely, work). The Bureau of the Census produces yearly data on work disability from its annual March Income Supplement to the Current Population Survey (CPS). Most of the data in this section derive from this survey. A slightly broader definition of work and disability is provided by the NHIS in its measurement of work limitation, which is also presented in this section.

Topic Questions:

How many people are considered to be work disabled?
How many work disabled persons are in the labor force or are unemployed?
How many work disabled persons are working full time?
How do the states differ in numbers of people with work disabilities?
How many persons have a severe work disability?
How many people are limited or unable to work because of a health condition?
What chronic health conditions are the most frequent causes of work limitation?
How do occupational injuries and illnesses affect work disability?
What types of occupations are held by people with work disabilities?
What are the earnings of someone with a work disability?
Do disabled workers live alone or with their families?
How many people in institutions have a work disability?
How many people with disbilities does the Vocational Rehabilitation system help?

How many people are considered to be work disabled?

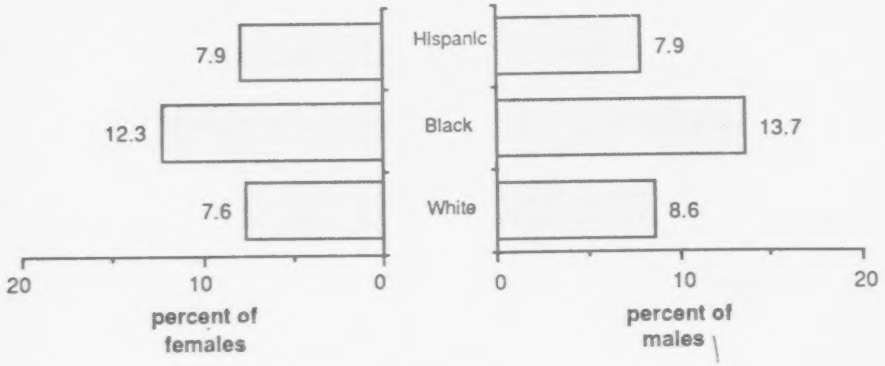
The number of noninstitutionalized people in the United States with a **work disability** is estimated to be 13.3 million, which represents 8.6% of the working age population (16 to 64 years old).

Higher percentages of blacks are work disabled than whites or Hispanics. This pattern is most apparent in numbers for men and women, where 13.7% of black men and 12.3% of black women are work disabled compared with 8.6% of white men and 7.6% of white women, and 7.9% of Hispanic men and 7.6% of Hispanic women who are work disabled.

Work disability increases in frequency with age. At 16-24 years, 3.5% are work disabled; for 25-34 years, the proportion rises to 5.4%; for 35-44 years, 7.5%; from 45-54 years, 11.0%; and for 55-64 years, 22.2% are work disabled.

Technical Note: The Hispanic category can include people of any race.

Higher percentages of blacks are work disabled.

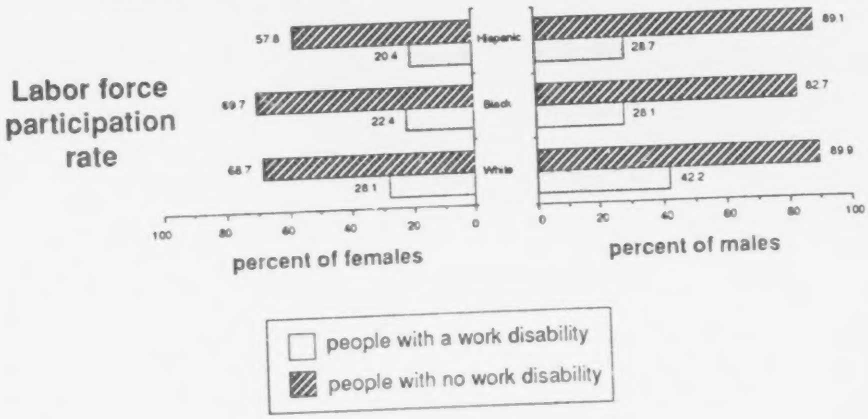


Source: Bureau of the Census, Preliminary Special Studies Report
Survey: CPS, 1987

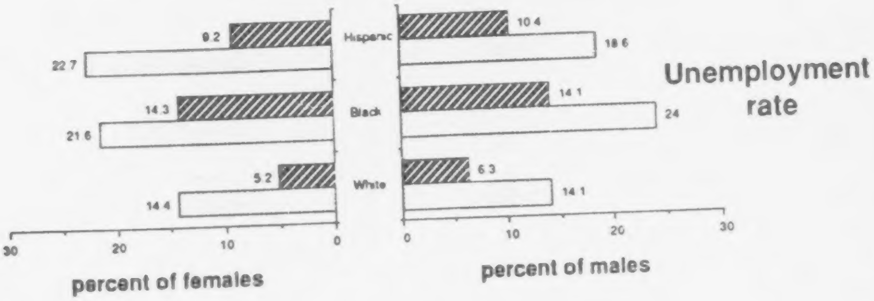
How many work disabled persons are in the labor force or are unemployed?

There are several ways to look at the employment of people with **work disabilities**. Two common ways shown below are the **labor force participation rate** and the **unemployment rate**. Of the 13.3 million people with a work disability, 33.6% are in the labor force and 15.6% are unemployed. These values are very different from those of the population with no disability (140.9 million) which has a labor force participation rate of 78.5%, and an unemployment rate of only 6.8%. The breakdowns for sex, race, and ethnicity are shown below.

Much less of the work-disabled population is in the labor force than the nonwork-disabled population.



Unemployment is much higher among work-disabled than nonwork-disabled people.

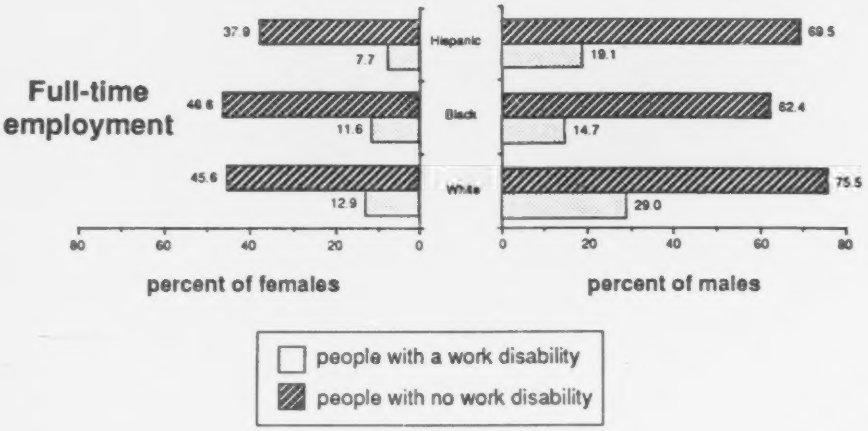


Source: Bureau of the Census, Preliminary Special Studies Report
Survey: CPS, 1987

How many work disabled persons are working full-time?

Another way to look at employment of people with a work disability is through **full-time employment** rates. Only 19.7% of the 13.3 million people with a **work disability** are employed full-time. In comparison, 59.4% of nonwork disabled people are employed full-time. The difference is true regardless of sex, race, or ethnicity. Work disabled persons are employed full-time 2.5 to 5 times less than their nonwork disabled counterparts of the same sex, race, and ethnicity.

People with a work disability are 3 to 4 times less likely to work full time, year round than those with no work disability.

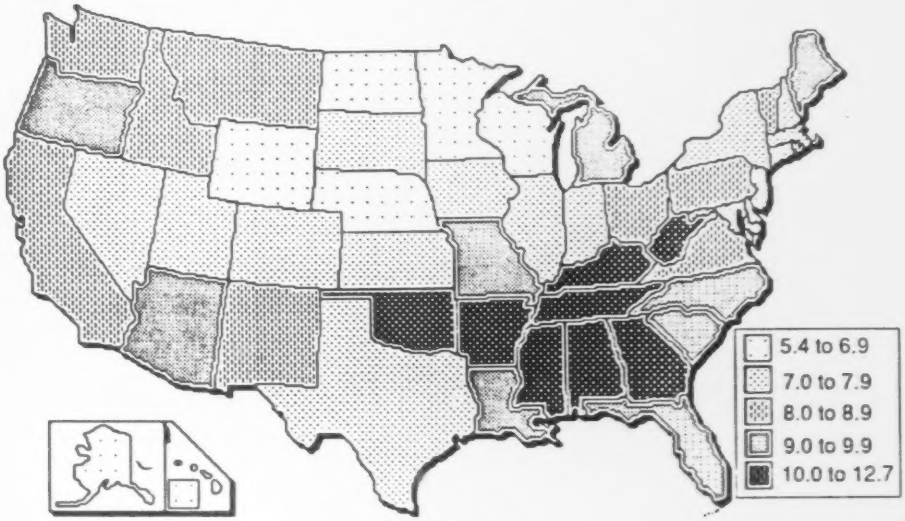


Source: Bureau of the Census, Preliminary Special Studies Report
Survey: CPS, 1987

How do the states differ in numbers of people with work disabilities?

States where the proportion of persons aged 16-64 with **work disabilities** is the highest are concentrated in the southern United States. The top 10 in percentage of disabled working age persons are: 1) Arkansas (12.7%); 2) West Virginia (12.3%); 3) Mississippi (11.8%); 4) Kentucky (11.4%); 5) Oklahoma (10.8%); 6) Alabama (10.6%); 7) Georgia and Tennessee (10.4%); and 9) Florida, Oregon, and District of Columbia (9.9%). The lowest proportions are: 51) Alaska (5.4%); 50) Hawaii (5.9%); 49) Wyoming (6.1%); 48) Connecticut (6.5%); 47) North Dakota (6.7%); 46) Wisconsin (6.8%); 45) New Jersey (6.9%); 44) Nebraska and Minnesota (7.0%); and 42) Iowa and Colorado (7.2%). Numbers of people with a work disability range from 1.3 million in California to 15,000 in Alaska.

The highest rates of work disability occur in the South.



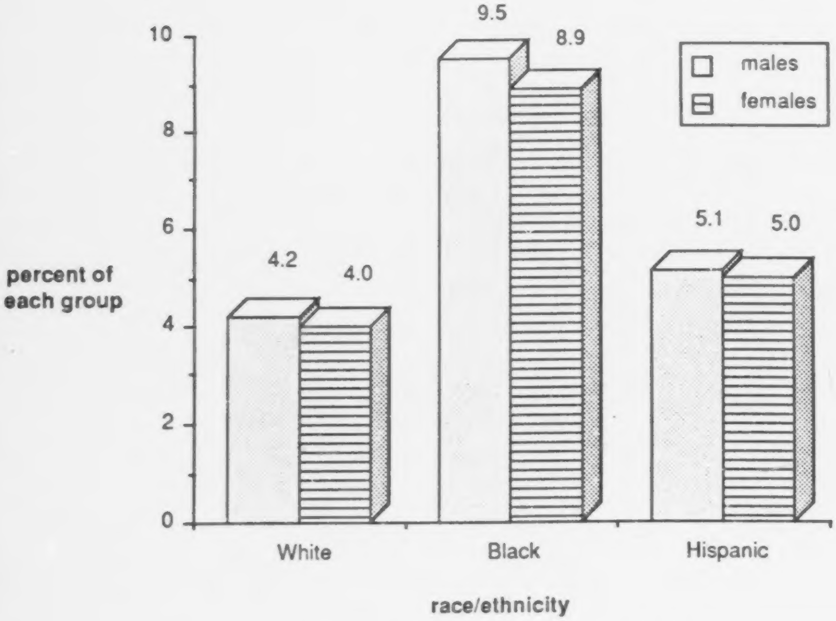
percent of 16-64 year olds with a work disability

Source: Bowe, **U.S. Census and Disabled Adults**
Survey: 1980 Census

How many persons have a severe work disability?

There are an estimated 7.25 million people of working age (16-64) who have a **severe work disability**. Working age persons who have a severe work disability constitute 4.2% of white males (2.75 million people), 9.5% of black males (1.65 million), 5.1% of Hispanic males (599,000), 4.0% of white females (2.7 million), 8.9% of black females (868,000), and 5.0% of Hispanic females (294,000).

The proportion of working age blacks who have severe work disabilities is higher than for whites or Hispanics.



Source: Bureau of the Census, Preliminary Special Studies Report
Survey: CPS, 1987

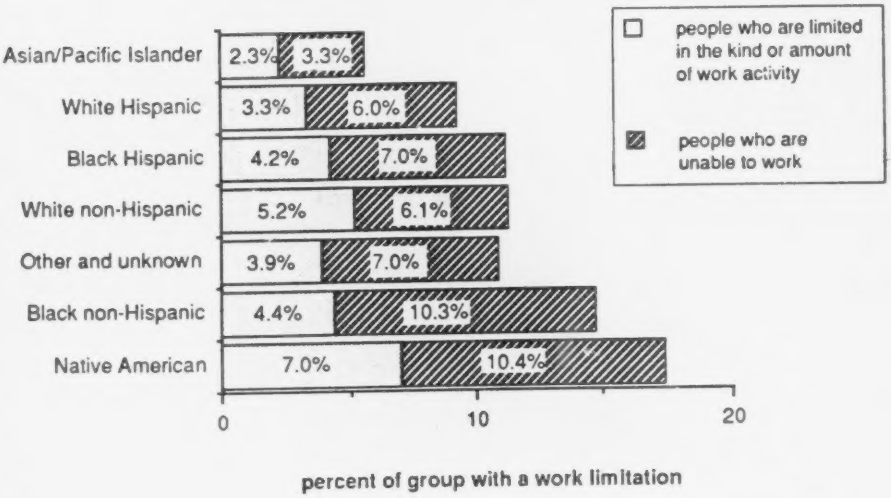
How many people are limited or unable to work because of a health condition?

For people between 18 and 69 years of age, work can be considered to be the **major activity**. Measuring **work limitations** due to a **chronic health condition**, an estimated 9.9 million of these people are unable to work (6.6%), while another 7.5 million are limited in amount or kind of work activity (4.9%). For females, 6.8% are unable to work while an additional 4.6% are limited compared to 6.3% of males unable to work and 5.3% who are limited.

As age increases, so does the impact of chronic conditions on ability to work. Only 1.8% of 18-24 year olds are unable to work, but the rate rises to 23.6% for 65-69 year olds. Similarly, 2.3% of 18-24 year olds are limited in amount or kind of work activity which rises to 9.8% for 65-69 year olds.

Technical Note: These data are from the National Health Interview Survey (NHIS), while the previous pages on work disability are from the March Supplement of the Current Population Survey (CPS). As noted earlier, the NHIS has a broader definition of work and disability (see glossary under **work limitation** and **work disability**).

Asians and Pacific Islanders report the fewest limitations in work activity.



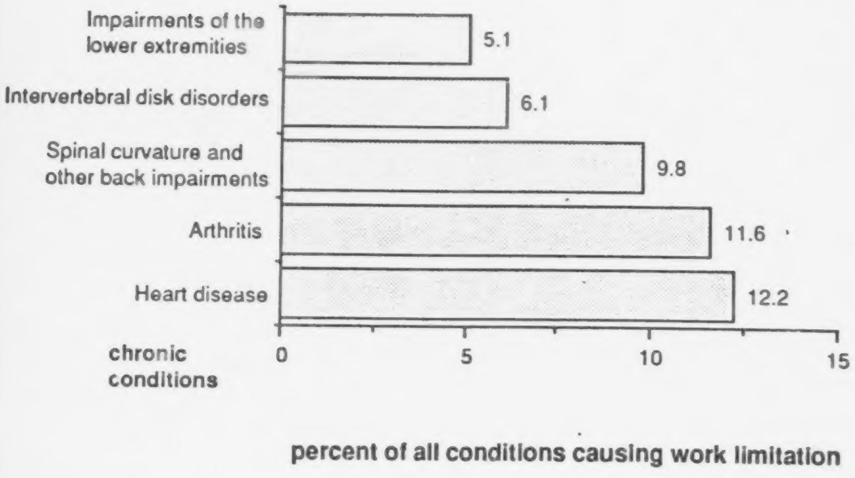
Source: LaPlante
Survey: NHIS, 1983-1985

What chronic health conditions are the most frequent causes of work limitation?

The **chronic health condition** most frequently reported to cause **work limitation** is heart disease (2.1 million conditions - 12.2% of all conditions cited as causing work limitation), followed by arthritis (2.0 million - 11.6%), spinal curvature and other back impairments (1.7 million - 9.8%), intervertebral disk disorders (1.1 million - 6.1%), and impairments of the lower extremities (883,000 - 5.1%).

Technical Note: Chronic condition groups are based on the International Classification of Diseases (ICD-9) codes as adapted by National Center for Health Statistics.

The top five chronic conditions causing work limitation.

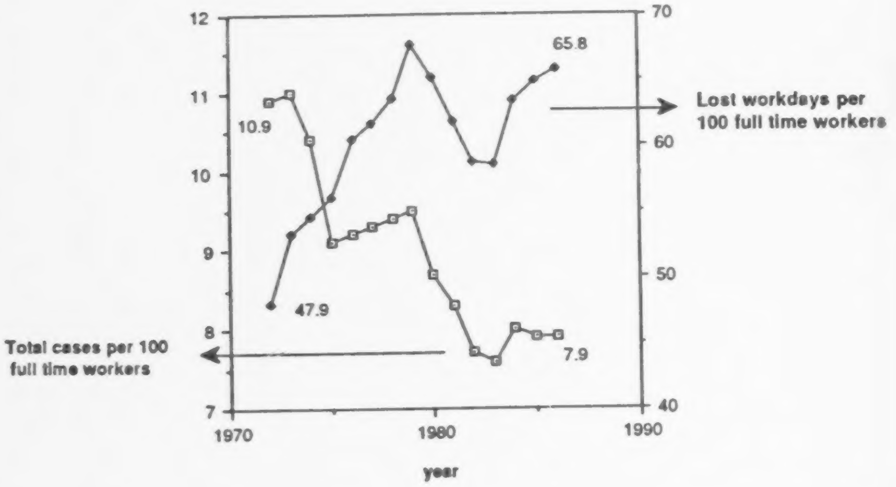


Source: LaPlante
Survey: NHIS, 1983-1985

How do occupational injuries and illnesses affect work disability?

Occupational injuries and illnesses also contribute to **work disability**. Over the past 15 years, the number of occupational injuries and illnesses has decreased, but the impact has increased. In 1972, 10.9 cases of injury or illness were recorded for every 100 full-time workers. By 1986, that incidence rate had dropped to 7.9 cases per 100 workers. In 1972, they caused 47.9 lost work days per 100 workers, whereas by 1986, the rate had increased to 65.8 lost workdays per 100 workers.

The effect of occupational illnesses and injuries has increased over the last 15 years.



Source: Bureau of Labor Statistics
Survey: ASOII, 1972-1986

What types of occupations are held by people with work disabilities?

The distribution of people with **work disabilities** in various occupations differs from the distribution of people without work disabilities. The most frequent occupational group for men with a work disability is operators/laborers (24.0%) compared to 20.6% of men without a work disability. Most men without a work disability, 25.5%, are managers/professionals while only 18.5% of work disabled men held those positions.

Women with a work disability are most frequently in technical/sales/administrative support (41.9%) and service (28.0%) positions. Women without a work disability are also mostly working as technical/sales/administrative support (45.4%), but there are many more working as managers/professionals (25.2%).

People with a work disability are less likely to be managers or professionals.

PERCENT DISTRIBUTION	with a work disability		without a work disability	
Employed	100.0 %		100.0 %	
	males	*females*	*males*	*females*
OCCUPATIONAL GROUP				
Managerial and professional specialty	18.5	16.9	25.5	25.2
Technical, sales, and administrative support	18.4	41.9	19.8	45.4
Service	12.3	28.0	9.6	17.3
Farm, forestry, and fishing	4.9	1.3	4.0	0.9
Precision, production, craft, and repair	21.6	2.2	20.1	2.2
Operators, fabricators, and laborers	24.0	9.4	20.6	8.8

Source: Bureau of the Census, Preliminary Special Studies Report
Survey: CPS, 1987

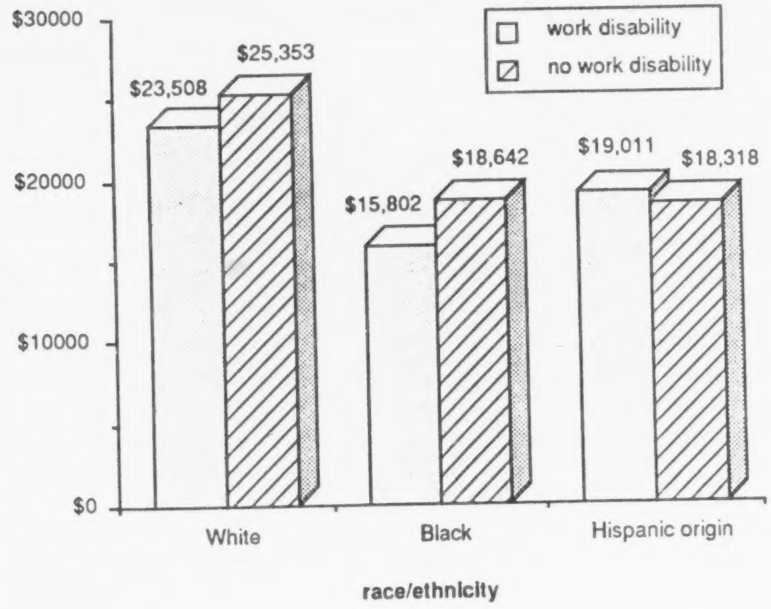
What are the earnings of someone with a work disability?

The **median annual income** of persons with a **work disability** is $6,434, while for people with no work disability it is more than twice as much ($13,403).

Earnings of disabled workers in **full-time employment** differ slightly from that of workers with no work disability. The mean earnings of white workers with a work disability are $23,508 compared to $25,353 for white workers without a work disability. For blacks, $15,802 is the mean earnings of full-time disabled workers as opposed to $18,642 for workers without a work disability. For Hispanic full-time workers, workers with a disability earn slightly more than workers without a disability ($19,011 compared to $18,318).

Technical Note: Earnings are in 1987 dollars. Persons of Hispanic origin can be of any race.

The difference between the earnings of people with and without work disabilities is slight for year round full-time workers.



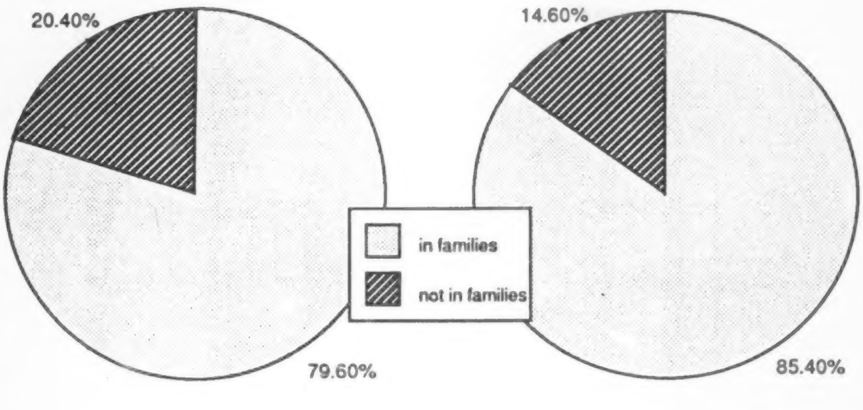
Source: Bureau of the Census, Preliminary Special Studies Report
Survey: CPS, 1987

Do disabled workers live alone or with their families?

Of the 13.3 million people with a **work disability**, 79.6% live with their families. The **mean family income** for these families is $26,144. Of the 140.9 million people with no work disabilities, 85.4% live with their families, which have a mean income of $40,480. The people with work disabilities who live with unrelated individuals have a mean income of $9,603 compared with $18,718 for those with no work disabilities.

Technical Note: Income is 1986 dollars.

People with work disabilities are less likely to live with their families than people with no work disabilities.



People with a work disability

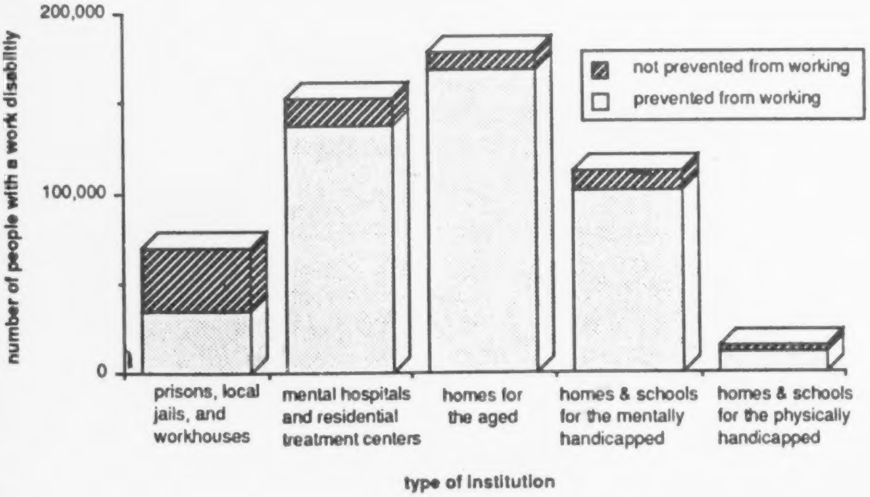
People with no work disability

Source: Bureau of the Census, Preliminary Special Studies Report
Survey: CPS, 1987

How many people in institutions have a work disability?

Two and one-half million people are residents of institutions in the United States. Of the estimated 460,000 persons aged 16 to 64 in prisons, local jails and workhouses, 69,000 (15.1%) have a **work disability**. Of the 187,000 people in mental hospitals and residential treatment centers, 152,000 (81.8%) have a work disability. An estimated 93.8% of the 189,000 persons aged 16-64 receiving care in homes for the aged have a work disability. Likewise, high amounts of work disability are evident for persons receiving care in homes and schools for the mentally handicapped (94.5% of the 118,000 persons), and homes and schools for the physically handicapped (91.1% of the 15,000 persons).

Work disabilities for institutionalized people are usually severe enough to prevent them from working.

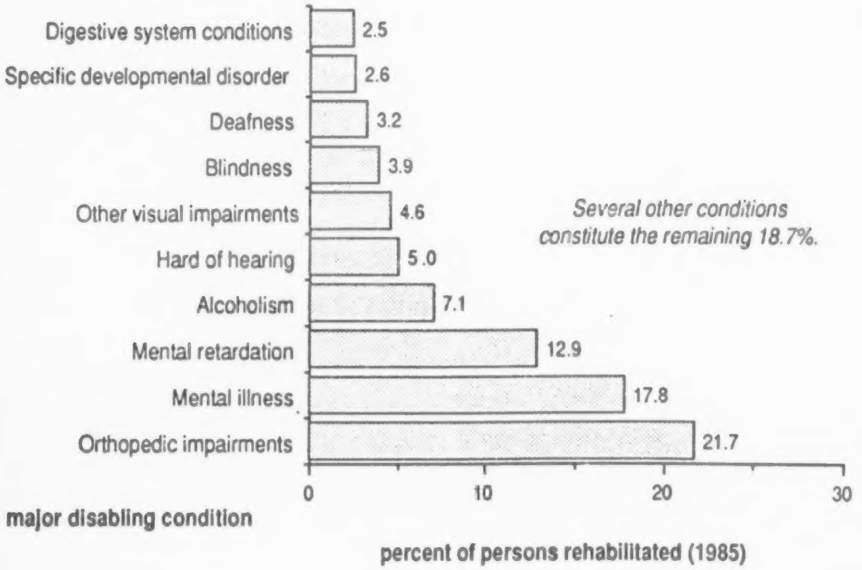


Source: Bureau of the Census, PC80-2-4D
Survey: U.S. Census, 1980

How many people with disabilities does the Vocational Rehabilitation system help?

The state-federal **vocational rehabilitation** (VR) program provides services for individuals with disabilities, assisting them in obtaining employment. The program, authorized by the Rehabilitation Act of 1973, as amended served 917,482 persons in FY1987, including 583,688 with severe disabilities. That year, 219,616 individuals, including 136,442 with severe disabilities, were **rehabilitated**, or successfully completed their VR services and found work in a variety of jobs. Types of conditions and impairments that people served by VR have are shown below.

Vocational rehabilitation serves people with varying types of disabilities.



Several other conditions constitute the remaining 18.7%.

Source: Rehabilitation Services Administration, 1988
Data Year: 1985, 1987

Study No. 854009

THE ICD SURVEY OF DISABLED AMERICANS

BRINGING DISABLED AMERICANS INTO THE MAINSTREAM

A Nationwide Survey
of 1,000 Disabled People

Conducted for

ICD-International Center for the Disabled
New York, New York

in cooperation with the

National Council on the Handicapped
Washington, DC

March 1986

Project Directors:

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New York, New York

CHAPTER 5: WORKING OR NOT WORKING: THE GREAT DIVIDE

These findings examine the employment status of disabled people, contrasts between disabled people who do or do not work, and the impact of working or not working on self-perception and satisfaction with life.

Employment Status of Working Age Disabled Americans

Not working is perhaps the truest definition of which it means to be disabled in this country. Two-thirds of all disabled Americans between age 16 and 64 are not working. Only one in four work full-time, and another 10% work part-time (Table 20). No other demographic group under 65 of any size has such a small proportion working. Young blacks, a group often singled out because of their very high level of unemployment, are much more likely to be working than are disabled Americans.

> Observation:
>
> It is in the area of work, even more than social life and activities, that disability excludes people most from mainstream American life. For most Americans, striving to reach one's abilities amounts to working to achieve career and financial goals. Our society expects people to work, and the preeminent criterion by which a person is judged and measured is the job that he or she does. Americans below retirement age, who do not work, live somewhat apart from the mainstream of life in this country. Unemployment excludes them from many of the common experiences known by most Americans.

Non-working disabled persons describe their employment status as follows: 4% are unemployed and actively looking for work; another 7% are unemployed but not looking for work; 29% say that they are unable to work because of their disability; 9% are retired; 9% keep house; 6% are full-time students, including those in vocational rehabilitation programs; and 1% say that they do volunteer service full- or part-time.

Q.23

Table 20

EMPLOYMENT STATUS OF WORKING AGE DISABLED PERSONS

Base: 703 respondents aged 16-64

Q.: Which of the following categories best describes your current employment situation?

	%
Working	33
Full-time	24
Part-time	10
Not Working	66
Unemployed and looking for work	4
Unemployed but not looking	7
Unable to work because of disability/ health problem	29
Retired	9
Keeping house	9
Full-time student/trainee or in vocational rehabilitation	6
Full- or part-time volunteer service	1
Not sure/refused	1

Percent Who Want to Work

The survey asked non-working disabled Americans under age 65 if they would like to be working. A substantial 66% majority said that they would like to have a job (Table 21).

Observation:

This finding -- that most non-working disabled persons want to work -- is one of the most important and challenging findings in the survey. The challenge is how society can effect policies and programs which will bring these people into the working mainstream.

Table 21

PERCENT NOT WORKING WHO SAY THEY WANT TO WORK

Base: 372 working-age disabled persons currently not working

Do or Do Not Want to Work	Disabled Persons Aged 16-64 Who Are Not Working*
Want to work	66
Do not want to work	34

---

*Asked of all working-age unemployed persons, persons unable to work due to disability, retired persons, housekeeping, and volunteers. Not asked of students.

Percent In or Out of the Labor Force

Another way of looking at disabled persons' work status is by the proportion who are in or out of the labor force, as defined by the Census Bureau. (The Census defines the labor force as those currently working full- or part-time, and unemployed persons who have actively sought work in the past month.) Sixty-two percent of disabled persons aged 16 to 64 are out of the labor force -- not working and not looking for work (Table 45). These people must therefore depend on insurance or benefits checks for support, or on the support of someone else.

> Observation:
>
> The result offers another significant measure of isolation from the mainstream; and certainly a more significant measure than the basic unemployment rate. (The unemployment rate includes only those persons who are unemployed and actively looking for work in the past month -- about 4% among working-age disabled persons.)

Comparisons Between Working and Non-Working Disabled Persons

Working disabled persons are younger, better educated, and have higher incomes than do those who do not work (Table 22).

-- About four times as many working disabled persons have a four-year college education, as do those who don't work. And far fewer working disabled persons never finished high school (22%) than have the non-working majority (43%).

-- Over twice as many working disabled persons report a 1984 household income of $25,000 or more (44%) as do those who don't work (21%).

One of the few demographic similarities between the two groups is that both are divided about evenly between men and women. A small majority of those working are men (54%), and a small majority of those not working are women (53%).

As might be expected, working disabled persons are less limited in their activities and less severely disabled than are non-working disabled persons (Table 23). A 64% majority of those who work described their disability as slight or moderate. But an equally large majority (61%) of those who don't work described their disability as somewhat or very severe.

More working disabled persons became disabled earlier in life than did those who don't work (Table 23).

Observation:

This last finding suggests that those who become disabled late in life have more difficulty adjusting to their disabilities.

Table 22

A COMPARISON BETWEEN WORKING AND NON-WORKING DISABLED PERSONS ON KEY DEMOGRAPHIC VARIABLES

	Working Disabled Persons	Non-Working Disabled Persons
Base	244	454
	%	%
Age		
16-24 years	9	12
25-34 years	23	9
35-44 years	30	12
45-54 years	18	20
55-64 years	19	47
Income		
$7,500 or less	9	29
$7,501 or $15,000	20	25
$15,001 to $25,000	21	17
$25,001 to $35,000	20	10
$35,001 to $50,000	13	7
$50,001 to more	11	4
Education		
Less than high school	22	43
High school graduate	34	34
Some college	17	15
Four-year college graduate or more	27	7
Marital Status		
Married/living together	70	56
Single	16	19
Divorced/widowed/separated	14	25
Sex		
Male	54	47
Female	46	53

Table 23

A COMPARISON BETWEEN WORKING AND NON-WORKING DISABLED PERSONS ON KEY MEASURES OF DISABILITY

Base: Those aged 16-64

	Working Disabled Persons	Non-Working Disabled Persons
Base	244	454
	%	%
Onset of Limitation		
Birth to adolescence	20	16
Young adult	41	22
Middle age	18	31
After age 55	7	23
Not limited at all	12	7
Limitations of Activities		
Cannot work, keep house, etc.	15	58
Limited in amount or kind of work	57	29
Other activities limited	16	6
Not limited at all	12	7
Severity of Disability		
Slight	29	8
Moderate	35	29
Somewhat severe	27	30
Very severe	7	31

Self-Perception and Satisfaction With Life

There are profound differences of self-perception between working and non-working disabled persons. A 59% majority of non-working disabled persons aged 16 to 64 consider themselves disabled. Only one in four (26%) working disabled persons consider themselves disabled (Table 24).

Working disabled persons also express more satisfaction with life than do those who don't work. Eighty percent of those who work say that they are at least somewhat satisfied with life, compared to 62% of those who don't work (Table 24).

Many more non-working disabled persons also say that their disability has prevented them from reaching their full abilities as a person than do those who work. Six out of ten (60%) non-working disabled persons believe this, compared to 47% of working disabled persons (Table 24).

> Observation:
>
> The findings in Table 24 demonstrate how work shapes the self-perceptions and experiences of people in this society.
>
> These findings also offer qualitative evidence of how non-working disabled persons' experiences differ even more from those of most Americans, than do the experiences of working disabled persons.

Table 24

A COMPARISON BETWEEN WORKING AND NON-WORKING DISABLED PERSONS OF SELF-PERCEPTION, SATISFACTION WITH LIFE, AND EFFECTS OF DISABILITY ON REACHING ABILITIES AS A PERSON

Base: Those aged 16-64

	Working Disabled Persons		Non-Working Disabled Persons	
Base	244		454	
	%		%	
Self-Perception				
Considers self disabled	26		59	
Does not consider self disabled	73		41	
Satisfaction With Life				
Very satisfied	48	80	32	62
Somewhat satisfied	32		30	
Neither satisfied nor dissatisfied	4		3	
Somewhat dissatisfied	12	15	21	33
Very dissatisfied	3		12	
Not sure/refused	1		2	
Effects of Disability on Reaching Abilities as a Person				
Disability has prevented person from reaching abilities	47		60	
Has not prevented person from reaching abilities	51		37	
Not sure/refused	2		2	

Job Satisfaction and Duration of Employment

The vast majority of disabled persons currently working full- or part-time express satisfaction with their jobs. Fifty-two percent say that they are very satisfied, and 31% are somewhat satisfied (Table 25).

Only 13% of those working express dissatisfaction with their jobs, and 5% are neither satisfied nor dissatisfied.

A 58% majority of disabled persons who work full-time have worked full-time for at least five years without interruptions of a month of more -- another indicator that those who work are less limited in their activities and less severely disabled (Table 26).

Observation:

Table 26 also suggests something of great import: that many disabled persons are able to hold full-time jobs steadily for many years, without long periods of absence.

Q.24,34

Table 25

JOB SATISFACTION AMONG THOSE WORKING FULL- OR PART-TIME

Base: All disabled persons currently working full- or part-time

Q.: How satisfied are you with your job -- the kind of work you do? Are you very satisfied, somewhat satisfied, neither satisfied nor dissatisfied, somewhat dissatisfied, or very dissatisfied?

	Total
Base	260
	%
Very satisfied	52
Somewhat satisfied	31
Neither satisfied nor dissatisfied	5
Somewhat dissatisfied	9
Very dissatisfied	4
Not sure/refused	-

Q.26a

Table 26

HOW LONG DISABLED PERSONS WHO WORK FULL-TIME HAVE WORKED WITHOUT INTERRUPTIONS

Base: Disabled persons working full-time

Q.: How long have you worked full-time without interruptions of a month or more, except for vacations? This includes all employers you may have worked for, and self-employment.

	Disabled Persons Working Full-Time
Base	174
	%
Have Worked Full-Time Without Interruptions:	
6 months or less	8
6 months to 1 year	4
1 to 2 years	11
2 to 3 years	7
3 to 4 years	4
4 to 5 years	6
5 to 10 years	17
10 to 20 years	21
20 years or more	20
Not sure/refused	1

Working in an Office or at Home

The great majority of disabled persons -- both those working and those not working -- would prefer to work in an office or other workplace, and not at home. Seventy percent say that they prefer to work in an office, and only 26% would prefer to work at home (Table 27).

Observation:

This finding provides yet another measure of how disabled persons want to be part of the mainstream of American life. Seven out of ten prefer to work outside of their home, like most working Americans do.

Q.31b,80d

Table 27

PERCENT WHO PREFER TO WORK IN AN OFFICE, OR AT HOME

Base: 596 working and non-working disabled persons aged 16-64

Q.: Would you prefer to work at home or would you rather work in an office, factory, or other workplace?

Q.: If you were working, would you prefer to work at home, or would you rather work in an office, factory, or other workplace?

	Total	Working Disabled Persons	Non-Working Disabled Persons
Base	596	244	352
	%	%	%
Would prefer to work at home	26	24	27
Would prefer to work in an office or other workplace	70	72	68
Not sure/refused	4	4	4

STATEMENT
FOR THE
U.S. BIPARTISAN COMMISSION
ON COMPREHENSIVE HEALTH CARE

Submitted by Aetna Life Insurance Company
CIGNA Corporation
Metropolitan Life Insurance Company
The Prudential
The Travelers Companies

November 8, 1989

This statement is submitted on behalf of The Prudential Insurance Company of America, CIGNA Corporation, Metropolitan Life Insurance Company, Aetna Life Insurance Company, and The Travelers Companies. These five companies, collectively, provided health benefits protection through network-based managed care programs to over 10 million Americans in 1989. These benefits are provided through more than 350 networks, including some 335,000 providers.

The American health care system is a unique mixture of public and private financing and delivery mechanisms, and its strength comes from that mixture. Our private sector approach provides flexibility and innovation in both the financing and delivery of health care. For the continued success and improvement of the health care system, it is essential that the role of the private sector be maintained. A health care system operated or financed entirely by government or under its sole control would ultimately diminish the quality of care and potentially restrict access to care, as experienced in Canada and Great Britain with the rationing of services.

There are serious weaknesses in the present system: insufficient mechanisms and incentives to stimulate efficiency; the absence of a coordinated system for delivering care; the failure to finance coverage for all Americans; and a concentration of resources on highly intensive acute care to the detriment of basic health care needs. These can best be overcome by a fundamental change in policy focus.

We believe it is critical that the Commission focus on the structure of the health care delivery and financing system. An increase in Federally funded benefits without a fundamental change in the system for providing care will inflate the cost of the system and ultimately lead to the reduction of quality of health care and access to it. Access can best be improved by introducing a more rational method of financing and delivery which will make coverage more affordable. Specifically, we believe that health care financing and delivery should be organized around managed care systems, operated by a variety of private sponsors, serving both public and private beneficiaries.

The insurance companies submitting this statement are placing greatly increased emphasis on developing, marketing, and operating plans which provide managed care services. By this term we refer to a plan which arranges with providers to furnish health care services to its members; has explicit standards for the selection of the providers who provide the health care; has organizational arrangements for an ongoing quality assurance and utilization review program for the care provided by its selected providers; and, in certain plans, gives patients the opportunity to choose, when they need care, whether to use the providers selected by the plan or non-plan providers, with financial incentives to use plan providers.

Managed care is winning increasing acceptance in the marketplace. More than 32,000,000 Americans now receive their care through some type of HMO; membership in HMO plans has tripled just since 1981. Many more Americans benefit from other forms of managed care. In just two years managed care plans have grown from 41% of the market to 71%. Fee-for-service plans that manage care have increased from 18% to 37% of the market. Programs permitting patients to choose, at the time treatment is needed, whether to use plan providers or to go outside the plan have increased from 9% to 16% of the market. And HMOs have increased their share of the market from 14% to 18%. When this Commission considers the nature of the private health care insurance market, it should not think of it only as traditional, fee-for-service, indemnity insurance; the market is rapidly moving toward managed care systems.

The managed care community is committed to refining its management techniques and improving its marketing to win greater acceptance of managed care. Recommendations by this Commission that the health system be structured through managed care would be important in fostering the attitudes in the health care community and among employers and employees necessary for managed care to thrive. Recommendations by this Commission against the erection of unreasonable legal barriers to the operation of managed care plans would further assist our efforts to foster managed care.

We urge the Commission to emphasize the importance of maintaining the private sector role in health care; to articulate the benefits of managed care to quality, access, and cost containment; and to recommend as policy that barriers to managed care be removed and preempted by the Federal Government.

The elements of managed care

We have strongly held opinions concerning the kinds of managed care plans that will be most effective over the long term in providing quality care at reasonable cost. However, at this stage in the evolution of the concept and development of the market, managed care should not be encased in a definitional straitjacket. Although traditional HMOs continue to be the most popular and proven form of managed care, the field should be encouraged to experiment with different systems and to compete to determine which are most effective and can win market acceptance. The sponsors of managed care must provide products that meet the demands of employers and their workers and evolve to meet changing demands. This competition has led to the development of new products that are more flexible than the traditional HMO, but more structured than the conventional indemnity plan. We are continuing to develop new concepts of managed care and new understandings of what it can accomplish.

Effective managed care plans, however, do share, in varying degrees, certain attributes. They furnish a comprehensive range of services through a network of participating providers. They organize and integrate the resources devoted to providing care, from primary care to highly specialized institutional services, and assure the delivery, or deliver to the patient the most appropriate level and type of care. They implement guidelines and protocols developed by medical experts for determining appropriate care, which participating providers agree to follow. To the extent possible, providers are selected to participate on the basis of the quality of the care they provide and the efficiency with which they function. And existing practice is to continually monitor the performance of participating providers. Standards are developed to assess these factors, based on training, professional credentials, and performance. Agreements with providers implement utilization standards and payment mechanisms that create incentives for the appropriate and cost effective provision of care. To make those agreements effective, managed care plans also provide incentives for members of the plan to use the participating providers. Clearly, not all managed care plans fully incorporate all of these provisions at the current time, but many already do and all successful plans ultimately will include all of these provisions.

Because of the flexibility in the types of managed care offered, employers and their workers can determine which elements of managed care they want. Although these techniques are more effective when they are implemented in a coordinated manner through operational arrangements with participating providers, they can be used to advantage in indemnity plans as well. We have found that employees initially are reluctant to join plans which may not include every provider. However, as they become accustomed to using the providers selected by the plan, and see the quality and cost benefits derived from doing so, they tend to phase into plans offering more vigorous management of care.

The benefits of managed care

Appropriate care

Managed care provides the patient an easy and known entry point into the health care system at the most appropriate level, not through a hospital emergency room but through a primary care physician or other outpatient facility. It provides the patient professional assistance in determining the appropriate modalities of care and the appropriate provider, and it provides a continuum of integrated care with followup that providers who are not tied to a managed care system cannot perform.

More recently, many managed care plans are combining the benefit of a structured plan with the ability of patients to select their own physician. By giving the patient in these plans a point of service choice at the time treatment is needed, a member of a plan can choose between the providers selected by the plan and non-participating providers on the basis of quality and cost. To maximize the plan's benefit, an incentive is provided to the patient to use a participating provider. Typically, the plan will require a greater copayment if the patient uses a non-plan provider. But the patient has the choice, and has it at the most relevant time. This feature makes managed care more acceptable to employees than plans which have no mechanism for out-of-plan care and provide no assistance when a member uses a non-plan provider.

Quality

Quality in a managed care environment will be vastly improved as compared to traditional insurance plans that simply pay claims.

In a managed care environment quality is monitored and improved by a formalized process that addresses the qualifications of providers and the appropriateness of care furnished. All of our companies are making a major commitment to the development of technologies necessary to select cost efficient, quality providers of care and help to assure the outcomes of treatment for our patients.

Care is reviewed to ensure that it is delivered in accordance with the guidelines and standards developed by medical authorities. Treatments are avoided which the most current medical research shows are not proven to be efficacious. Managed care requires providers to consider the way they provide care in light of new learning and professionally developed guidelines, and avoids overutilization. The quality of care received by patients is enhanced; patients are not subjected to unnecessary or inappropriate modalities of treatment. The judgment of the best medical authorities is made available to individual patients' care-givers.

Contrary to the belief that utilization review impedes care, quality is monitored and enhanced by requiring prior approval for certain services, concurrent review during a hospital stay, and retrospective review of services to identify possible over- or under-utilization in a completed course of treatment. Case management is employed so the patient receives the most appropriate modality of service. Frequently, a physician serving as a primary care gatekeeper is charged with the responsibility to oversee the medical services furnished to the patients for which he or she is responsible. The assurance of the quality of care being provided is a key component of managed care plans and is often the basis upon which companies compete.

Cost effectiveness

Managed care arrangements are intrinsically structured to be cost effective. By avoiding over-utilization and matching patients with the appropriate level and situs of care, managed care is able to provide better care at a lower cost. A customary technique for cost containment in traditional insurance plans is to increase the copayments which covered employees must pay when they receive care. This shifts some of the risk to the employee, but does not give him/her the expertise or the bargaining power, and in fact even little incentive, to be a cost-effective purchaser of care. Managed care plans provide the needed cost-saving mechanism by their selection of providers and management of care, without requiring greater out-of-pocket copayment by employees.

More research is necessary to fully document the savings, but recent empirical evidence suggests the extent of the advantage of managed care. Group practice HMOs and IPAs in the years 1987 and 1988 were able to hold the rate of increase in premiums charged to employers to one-half that of conventional, indemnity insurance plans.

Flexibility

Managed care plans can achieve by negotiations, driven by market forces, what government fiat cannot. Managed care plans can negotiate utilization and fee requirements with providers which are acceptable to providers. Managed care pans can implement these flexibly and locally. Most importantly, managed care plans in a competitive market must always operate for the best interest of the patient. Managed care is the vehicle by which quality, efficiency, and customer satisfaction come together in a competitive marketplace. The patient is better served by such an arrangement than by the unilateral actions of government by budget pressures.

Increased access for the uninsured

Access to health care can best be expanded when the mechanisms for efficient, cost-effective delivery of care are in place. By constraining costs, managed care plans make the expansion of benefits to others more feasible. As managed care matures and is able to exercise its cost-constraining muscle, the system-wide increases in the cost of health care will be moderated, and coverage will be more affordable for everyone. As health care is provided more efficiently, it will be possible to provide more coverage to more beneficiaries, and to do so with less risk of further inflating health care costs.

One of the characteristics of managed care programs is that those individuals who are the sickest can realize the most benefit from managed care through case management. The techniques of managed care can constrain the cost of covering the high risk population and provide more appropriate care for them. To cover the necessarily high expense of caring for "uninsurables," a privately financed reinsurance mechanism should be established. Reinsurance would make coverage available and, if it is broadly and fairly subsidized by all financing entities, provide a way for the private sector to bear the cost of coverage.

What needs to be done

Increased attention is today being given to developing the techniques of managed care. Managed care has expanded beyond its based of traditional HMOs; providers, employers, traditional insurance companies, and sponsors of IPAs, PPOs, and new forms of HMOs are adopting managed care and developing new techniques. Building upon the studies of the past decade, a widespread and vigorous effort is being made to define, measure, and evaluate the appropriateness of particular procedures, to develop guidelines for care, and to fashion the best ways to put them into practice. Intensive efforts are underway to develop a variety of new management techniques. What is needed is the time, the policy atmosphere, and the legal framework for managed care to develop further.

Continued development and expansion of managed care will be fostered by:

1. An explicit recognition that managed care is an important vehicle for organizing the health care delivery system; this Commission's recommendations can help develop a national policy of emphasis upon managed care. Managed care could be used more extensively and effectively in government programs, and your policy direction could make that happen.

2. Identification of institutional and legal barriers which prevent managed care from fulfilling its full potential. The

Commission would assist this effort by publicly identifying types of laws which unreasonably encumber managed care. Managed care is threatened by laws that:

- Restrict the ability of third party payors to negotiate reimbursement rates with providers and require them to reimburse providers their reasonable, customary, and necessary charge determined by the providers; these laws would restrict the ability of managed care plans to develop more cost effective care.
- Require a managed care plan to pay the same fees to providers who are included in its system as those who are not; these destroy the incentives necessary to develop a managed care system and undermine its purpose.
- Restrict the rights of sponsors of managed care plans to contract selectively with a limited number of providers; these prevent managed care plans from obtaining the best and most cost conscious providers.
- Restrict the ability of plans to utilize primary care physicians; these restrictions limit plans' ability to ensure that appropriate and cost-effective treatment is provided.
- Limit the copayment that a managed care plan may require a beneficiary to pay if he uses a non-plan provider; these undermine the ability of a plan to give sufficient incentive to patients to use the network of cost-effective providers.

- Prohibit utilization review of certain treatments or conditions; these prohibitions gut a critical element of managed care.
- Require utilization review decisions to be made by residents of the state in which the treatment is offered; these make it difficult for national companies to participate in the local market and add unnecessary costs.

Federal preemption of state laws which hinder managed care plans and of laws which mandate the coverage that must be provided would give managed care a better opportunity to provide cost-effective, quality care.

* * *

We believe it is important for the Commission to stress the importance of maintaining the private role in the health care delivery system. Government assistance to help Americans afford health care need not and should not bring in its wake a Government takeover of the financing and delivery system.

We believe that a consensus is developing that managed care offers the best vehicle for providing high quality, cost-efficient, accessible health care. It is vital that this Commission reflect and reinforce that consensus. We ask it, therefore, to recommend that managed care plans be encouraged as a mainstream vehicle for financing and providing care and that barriers to the further development of managed care, such as those we have outlined in this testimony, be avoided.

Statement of

American Psychiatric Association
American Psychological Association
National Alliance for the Mentally Ill
Mental Health Law Project
National Association of State Mental Health Program Directors
National Mental Health Association
National Council of Community Mental Health Centers

before the

Pepper Commission

on

Access to Health Care for People with Mental Illness

November 15, 1989

Thank you, Mr. Chairman and Members, for the opportunity to submit testimony to the Pepper Commission on the special needs of people with mental illness for acute health care coverage.

This testimony is offered on behalf of a coalition on national organizations of mental health professionals, providers, advocates and consumers who have long been concerned about the failure of our health care system to provide the basic elements of acute care services to people in need of mental health services. The organizations which have endorsed this testimony are:

American Psychiatric Association
American Psychological Association
Mental Health Law Project
National Alliance for the Mentally Ill
National Association of State Mental Health Program Directors
National Council of Community Mental Health Centers
National Mental Health Association

The testimony reflects the general position of the Associations listed above. Individual associations may also submit separate statements addressing more specific issues. Our statement discusses the acute care needs of our population. Earlier, on October 6, we presented testimony addressing the long-term care needs of people who are functionally impaired by mental disorders.

I. Current Inadequate Coverage of Mental Health Services

A. Private Health Insurance

Obviously, the 37 million Americans without public or private health coverage have protection against neither physical or mental illness. And, among the 153 million people with private insurance plans in 1986, the access problems for people in need of mental health services is far more difficult than for those seeking physical health care. [1]

o Although 99 percent of individuals and their families had coverage for inpatient mental health treatment, only 37 percent had the same coverage as for treatment of other illnesses. Over 60 percent had either fewer days of coverage or a special annual or lifetime dollar maximum for mental illness. Further, the coverage in 1986 represented a deterioration from 1981 when 58% of persons with health insurance had equal impatient mental and non-mental health coverage.

o Only a small percentage (10.7%) of all participants were covered for partial hospital (day or night) treatment.

o For outpatient benefits, the coverage limitations were even more stringent. While 97 percent of persons with private health insurance had coverage for outpatient mental health benefits, only 6 percent had coverage equivalent to coverage for other illnesses. In general, multiple limits existed on number of visits covered (33%), total dollars reimbursable (68%), and/or percentage of allowable charge paid (48%)

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[1]. The data in this section is adapted from The Coverage Catalog, 2d edition, prepared by the Office of Economic Affairs of the American Psychiatric Association, American Psychiatric Press, Inc. 1989. It utilizes data from the 1986 Employee Benefits Survey conducted by the Bureau of Labor Statistics, as well as APA survey of 300 employer-sponsored benefit plans and Health Maintenance Organizations (HMO) in 1987 and the Federal Employees Health Benefits Program (FEHB) for 1989.

o For many participants, the outpatient dollar limits were severe. For example, only 24% of the plans reimbursed at higher than 50% of allowable charges. For participants in plans with annual dollar limits, over 77% had payment limits of $1,000 or less per year. While a majority of plans provided over thirty outpatient visits per year, when combined with limits on payment per visit and/or maximum annual reimbursement, combined

o Many private plans have "pre-existing" condition limitations or exclude "conditions not amenable to short-term therapy."[2]

In sum, inpatient and outpatient benefits in private insurance for mental illness are far less comprehensive than those for physical illness. Maximum benefits are lower, deductibles and co-insurance higher and the percentage reimbursed substantially smaller.

B. Public Health Programs

The two national programs providing access to mental health services are Medicare and Medicaid. Each covers a specific and limited segment of the population and neither provides comprehensive service coverage.

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[2]. Plan for Kaiser Permanente, Mid-Atlantic Region, quoted in The Coverage Catalog, p.173.

The Medicare program contains a number of special limitations relating to mental health services. Part A of the program contains a life-time limit of 190 days of care in a psychiatric hospital. Care in a psychiatric ward of a general hospital, however, is subject to the same limits as any other admission for non-mental health care. Part B limits reimbursement for outpatient mental health services to $1,100 per year, but only if the patient has incurred expenses of $2,200. (The program "recognizes" 62.5 percent of reasonable charges or $1,375 and pays 80% of the recognized amount. The 1989 OBRA, as passed by the House and reported by the Senate Finance Committee, would eliminate the $1,100 cap.) The service may be provided in an individual practitioner's office or as part of an organized care setting such as a community mental health center. Part B also covers partial hospitalization services when provided as part of the program of an accredited hospital. The program will also pay for services "incident to" a physician's service and reasonable and necessary for the diagnosis and treatment of the patient's condition.

In addition to almost everyone over age 65, persons with disabilities who have been on the SSDI roles for over two years are eligible for Medicare. An estimated 15 to 20 percent of the

2.8 million "workers" receiving SSDI benefits are classified as having "mental, psychoneurotic and personality disorders."[3]

Services for persons with mental illness through the Medicaid program defies easy generalization. We can say that overall the program includes less than 45 percent of all persons below poverty and that its full potential for services to mentally ill people has nowhere been achieved.[4] While the Medicaid program will reimburse states for a broad range of services, few take advantage of options available in the law to provide rehabilitation, personal care or case management services. States have discovered "legal" means to limit even the mandatory hospital inpatient and physician benefits for persons with mental illness. In addition, under the law persons between ages 22 and 64 are not eligible for inpatient services in an institution for mental diseases (IMD) defined as a hospital, nursing home or other institution of more than 16 beds primarily engaged in care, treatment or diagnosis of persons with mental diseases. Although such patients would be eligible for services in the psychiatric ward of a general hospital. In almost all states the mandatory outpatient hospital and optional clinic services have become the principal settings for provision of outpatient mental health services. Almost every state covers prescription drugs, including psychoactive drugs. In all states payments for services are below market rates creating a significant disincentive for many hospitals, physicians and other mental health professionals to treat Medicaid patients.

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[3] Background Material and Data on Programs within the Jurisdiction of the Committee on Ways and Means, 1989 edition, WMCP: 101-4, p. 5[illegible] The data indicates that about 11 percent of all new disabled worker beneficiaries between the years 1970 to 1982 were mentally impaired. The percentage increased rapidly thereafter rising to 18% in 1985 and 23% and 22% in 1987 and 1988 respectively. Since people with mental illness are likely to be younger when they enter the roles and to have a more normal life expectancy than persons with physical impairments, they make up a growing proportion of the current SSDI population.

[4] While somewhat dated, the most completed review of Medicaid mental health coverage can be found in Mental Health Benefits Under Medicaid: A survey of the States, January 1984, compiled by Gail Toff for the Intergovernmental Health Policy Project, Washington, D.C.

II. Scope and Prevalence of Mental Illness

The lack of comprehensive or, in many instances, even adequate mental health coverage needs to be juxtaposed against the scope and prevalence of mental illness or mental disorders in the United States, particularly among the working age population.

o In any six month period, approximately 29.4 million adult Americans (18.7 percent of the population) suffer from one or more mental disorders ranging from mild to serious, but for whom therapeutic intervention is appropriate.

o People aged 25 to 44, people in their prime working years, accounted for the largest percentage of admissions to inpatient psychiatric settings.

o Suicides by persons under age 35 was the third leading cause of death for this age group in 1982 and between 1958 and 1982, the number more than doubled.

o The locus and nature of mental health care has changed markedly over the 14 years from 1970 to 1984. Inpatient beds per

100,000 people decreased 57 percent, but inpatient treatment episodes decreased only 7 percent, indicative of significantly shorter inpatient stays. Concomitantly, outpatient care per 100,000 population in organized care settings (i.e. excluding patients served by private practitioners), increased over 135 percent during the same period.[5]

o In 1980, total expenditures for mental health care were estimated to be between $19.4 and $24.1 billion, representing about 8 percent of all expenditures for health care.

III. Principles for Mental Health Benefits in Health Insurance Programs.

Regardless of the specific scope or range of services ultimately recommended by the Commission, we believe that any health insurance proposal should be guided by the following principles.

A. Coverage of All Conditions - In light of the need for mental health services and shortcomings in existing coverage summarized above, the undersigned associations insist that mental health benefits must be an integral part of any set of recommendations addressing access to health care for the American people. Mental illness can be as debilitating as physical illness. Researchers at the Rand Corporation, for example, found that depressed people are as limited in their day-to-day functioning as those with a serious heart condition and even more limited than those with other major chronic disease such as lung or gastrointestinal problems, angina, hypertension or diabetes.[6] Accordingly, there is no basis to distinguish between physical and mental illness in terms of access, eligibility, and coverage.

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[5]. Mental Health, United States, 1987, Alcohol, Drug Abuse and Mental Health Administration, #(ADM) 87-1518, 1987, pp 32, 34 and 38..

B. Cost Containment - We recognize that any health insurance proposal adopted by the Commission must include cost containment measures. At the same time the Commission should ensure that the drive to curb spiraling costs is not at the expense of quality care or by excluding certain types of care. Cost containment alternatives for mental health services are discussed in greater detail below.

C. Comparability Between Public and Private Health Plans - The Commission should adopt a proposal which provides for equivalent coverage and reimbursement in both private and public health insurance plans. It is time to end the two-class health care system that exist now between private health care and Medicaid.

D. Spreading the Cost - Individuals, employers, and government should all contribute to a program which ensures access to health care for all. The undersigned organizations believe that the Commission should adopt a plan that fairly distributes the cost of a comprehensive health care program to all participants, except those unable to pay, in the system. Moreover, the lack of insurance and underinsurance for health services afflicts Americans regardless of age. We believe that any health insurance proposal should provide coverage for people of all ages.

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[6]. Journal of the American Medical Association, Vol. 262, No. 7, August 18, 1989.

E. Preexisting Conditions - No insurance carrier should be allowed to exclude people from coverage because of preexisting health conditions. Too often, carriers have used the presence of a pre-existing condition to deny both coverage and reimbursement for mental illness and many other chronic disorders and conditions. In fact, some insurers will deny coverage to persons who have a history of treatment for mental disabilities. We urge the Commission to recommend a prohibition on this practice.

F. Professional/Provider Policy - Different mental illnesses are amenable to an array of treatment alternatives by a range of mental health providers practicing within the scope of their licenses. The eligible mental health professional for the Commission's proposal should be determined by state licensure and professional practice laws or certification by national accreditation bodies. Both public and private organized care settings as well as individual practitioners should be eligible to provide services. We believe that consumers, including those who receive services through a panel or other form of managed care, should have access to a broad range of mental health providers.

IV. Comprehensive Services

A comprehensive range of mental health services should be available, both to adults and children. Such services should include acute care services for those with a range of mental and emotional problems as well as comprehensive services for individuals with long-term, serious mental illnesses.

For adults, the range of appropriate services would include the following:

o **Inpatient care in public or private general or psychiatric hospitals:** Reimbursement should be only for patients who receive "active treatment" services (not custodial care)as now required in the Medicare program.[7] If the Commission includes limitations on the number of covered days for mental and non-mental inpatient care, we urge that the Commission also provide for the extension of coverage through peer review of the medical necessity for further hospitalization.

o **Partial hospitalization:** Day (or night) treatment services furnished through either a hospital or a qualified free-standing program. Partial hospitalization is an intensive ambulatory treatment service offering less than 24-hours-a day care. The program is particularly appropriate for persons with serious mental disorders who are able to maintain themselves in the community. If the Commission's proposal limits inpatient days, there should be provision for a trade-off between inpatient care and partial hospitalization. The determination of the number of partial hospitalization services equaling one day of inpatient care can be established through actuarial analysis of the relative costs of the two modes of treatment. The availability of a trade-off would encourage the use of the least restrictive treatment setting based on the medical needs of the patient. Medicare currently includes partial hospitalization as a benefit for individuals with mental illness, but without provision for a trade-off against inpatient days.

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[7]. The American Psychological Association supports the language in S 768, Basic Health Benefits for All Americans Act, which provides reimbursement for "inpatient hospital care for a mental disorder."

o **Psychosocial rehabilitation:** A program of rehabilitative services focusing on the development of independent living and vocational skills and which provide supportive social programs including peer support. Psychosocial rehabilitation programs have been shown to be cost-effective in providing community care to adults with serious mental illness.[8]

o **Psychopharmacologic drugs:** Coverage of outpatient prescription drugs often essential to stabilizing and treating persons with mental illness.

o **Outpatient treatment:** A broad range of services provided by eligible mental health professionals which includes: assessment and diagnosis, emergency services and crisis care, individual, group and family psychotherapy, medical management of the mental disorder,[9] prescription of medication and medication monitoring. The eligible professionals should be determined by state licensure and professional practice laws or certification by national accreditation bodies. Both public and private organized care settings as well as individual practitioners should be eligible to provide services. We believe that consumers, including those who receive services through a panel or other form of managed care, should have access to a broad range of mental health providers.

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[8]. Bond, Gary, "An Economic Analysis of Psychosocial Rehabilitation," Hospital and Community Psychiatry, April 1984; and Weltman, Poveromo, Lori and Nofi, Ralph, "Impact of Community-Based Psychosocial Treatment on Clients' Level of Functioning," Hospital and Community Psychiatry, May, 1988.

o **Case management:** As appropriate, each individual with a serious mental illness should have receive case management services to help insure that an adequate treatment plan is developed and implemented and that services are coordinated.

For children, the range of appropriate services would be similar to those for adults, and would, in addition, include the following services:

o Inpatient care services in residential treatment centers (as well as hospitals).

o Day treatment: similar to partial hospitalization, but involving collaboration or at least close coordination of mental health treatment and education components.

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[9] . Clarification: The American Psychological Association and the National Council of Community Mental Health Centers would substitute "clinical management" for "medical management." The term "clinical management" recognizes that a range of mental health professionals (practicing within the scope of state licensure laws), including physicians, currently provide a variety of services, other than counseling, psychotherapy or diagnostic testing, that form a critical part of mental health treatment plans.

- o Early identification, assessment and intervention services
- o Intensive in-home services
- o Therapeutic foster care and therapeutic group homes

Other components of a complete package include cost sharing provisions and protection against catastrophic costs.

o **Cost-sharing provisions**: all copayment and deductible amounts and percentages for mental health benefits should be consistent with those required for other benefits in the Commission's recommendations. (We object to the discriminatory provision in the Kennedy-Waxman bill[10] which requires 50% copayment for outpatient mental health services, but 20% or less for other covered services.

o **Catastrophic cost protection**: Protection against the catastrophic costs of illness -- costs that can wipe out a family's savings and hope for future economic well-being -- is a vital ingredient of any insurance proposal. However, if a limited package of covered benefits are included for persons with mental illness, the "catastrophic protection" must be carefully designed to be workable. The approach adopted in the Kennedy-Waxman bill will not work.[11] It sets a $3,000 ceiling on out-of-pocket expenses based on the out-of pocket costs of "items and services provided under the plan." Under that approach, the catastrophic protection would not apply to mental health cost incurred after the covered services have been exhausted. For example, the cost of 46th day of hospital care would not be included within the calculation of the $3,000 limit.

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[10] . The Basic Health Benefits for All Americans Act. S768 and HR 1845.

[11] . The American Psychological Association supports the Kennedy Waxman bill, but recognizes the complexity of the catastrophic protection issue.

To partially rectify this problem, we recommend that the Commission, assuming limited benefits are recommended, permit an individual or family to add the costs of uncovered mental health services to otherwise eligible out-of-pocket expenses in determining the catastrophic limit. While this change would not solve the basic problem, it would permit a family with high mental health care costs to reach the cap faster and limit their financial exposure for non-mental health services covered under the plan.

V. Cost Containment

Mental health consumers, providers and advocates are well aware of the governments' and payors' need to ensure that benefits are delivered in the most cost efficient manner. Affordability is a major issue for us all.

Mental health services, more so than for other illnesses, are labor intensive. Therefore, the most effective way to keep care affordable is to ensure that only necessary services are delivered. Fundamental to appropriate utilization of these services is the provision of a comprehensive or balanced system of services. Inpatient hospitalization is by far the most expensive mental health service but is often the only one emphasized under private or public benefit plans. All too often, people with mental illness whose condition may require partial hospitalization or short-term crisis stabilization in the community must be hospitalized simply because they have exhausted their outpatient coverage. A comprehensive benefit package allows the application of both prior authorization and concurrent review mechanisms which assess individual patient needs and base placement decisions upon these assessed needs.

Well developed clinical assessment tools are now widely employed by large private sector payors which accurately assess individual clinical needs and allow for a reliable determination of the least restrictive, clinically appropriate treatment environment for the individual. The purpose of these mechanism is to establish whether the patient is ill enough to justify hospitalization, and while in the hospital, to ensure the patient is receiving the active treatment necessary for the diagnosed condition(s).

We urge that any restructured mental health benefit proposal include a system for prior authorization (except in emergencies) and concurrent and retrospective utilization review for inpatient services. Such a system may also be appropriate for patients who, after initial diagnosis and treatment, are prescribed long-term outpatient services. Prior authorization systems are now widely used by private payors for a variety of illnesses and are not used in an exclusive or discriminatory manner for mental illnesses. Many private payors employing such mechanisms report substantial savings in their mental health expenditures after implementing these mechanisms.[12] Such savings occur principally through reductions in the utilization of inpatient services.

Prospective payment for inpatient mental health care has been researched throughout the 1980's in an attempt to identify which patient characteristics are predictive of the need and utilization of hospital resources. Unlike many acute illnesses, a diagnosis of mental illness alone is a poor predictor of the need for hospitalization. Recent services research on mental illness has focused on other patient characteristics which have a higher predictive value of the need for hospitalization.[13] Our groups strongly support continuing investigations into predictors of hospital utilization and are optimistic that a patient classification system can be developed that will allow for the application of a prospective payment mechanism.

VI. Minimum Mental Health Benefits

Several health insurance proposals considered by Congress the last few years recognize the importance of mental health coverage and include at least minimum mental health benefits. The

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[12]. Diehr, P., Williams, S.J. and Martin, D.P., "Ambulatory Mental Health Services Utilization in Three Provider Plans," Medical Care, vol. 22, No. 3, March, 1984. Manning, W.and Wells, K. Use of OUtpatient Mental Health Care: Trial of a Prepaid Group Practice versus Fee-for-Service. Rand Corporation, 1985. Rodriquez, A. and Maher, J., "Psychiatric Case Management Offers Cost, Quality Control," Business and Health. 1986. Lee, R. "The Evolution of Managed Mental Health Care," Compensation and Employee Benefits Management. Vol. 5, No. 1, Autumn, 1988. Lee, R. "Employers Address Psychiatric and Substance Abuse Services," Health Span. Vol.3, No. 10, Nov.-Dec., 1986.

[13]. Wood, W. and Beardmore, D., "Prospective Payment for Outpatient Mental Health Services: Evaluation of Diagnosis Related Groups," Community Mental Health Journal, Vol. 22, No. 4, Winter, 1986. Morrison, et. al., A Study of Patient Classification Systems for Prospective Rate-Setting for Medicare Patients in General Hospital Psychiatric Units and Psychiatric Hospitals. Macro Systems, Inc., 1985.

Basic Health Benefits For All Americans Act (S 768 and HR 1845) ordered reported by the Senate Committee on Labor and Human Resources and pending before the House Committee on Energy and Commerce contains provisions for inpatient and outpatient mental health services. USA Health (HR 2980) sponsored by Rep. Roybal and presented to the Commission at the October 24th Hearing likewise covers mental health services. Finally, 26 states have legislated coverage of mental health services in the private health insurance plans offered in their state.[14]

We recognize that the Commission, because of cost considerations, may have to recommend a package of minimum benefits as a first step toward comprehensive coverage. To assist the Commission, we suggest, but do not endorse, the mental health services included in the Kennedy-Waxman bill. It would truly meet the definition of "minimum benefits."

Conclusion

The problems faced by Americans in obtaining adequate and affordable health insurance for their physical health needs are also faced by individuals with mental illness. Further, people with mental illness have the additional obstacles of inaccessibility of services, discrimination in coverage policy, and historic emphasis upon the public psychiatric hospital as the primary locus of care.

Our statement has emphasized three responses to these structural problems: comparability, parity and balance.

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[14] Taube, Mechanic and Hohman, The Future of Mental Health Services Research. NIMH, 1989.

o Public and private insurance coverage needs to be made comparable at a reasonable level of benefits, not the lowest common denominator.

o Coverage of physical and mental illness must be based on the principal of parity, so that discrimination in coverage against mental health services is ended.

o Coverage must include an array of mental health benefits so that care in not tilted toward one setting, e. g. the hospital, but is balanced by the availability of community based, non-inpatient services.

We look forward to working with the Commission and its staff as you develop specific recommendations for the Congress. Thank you.

STATEMENT

OF THE

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

TEACHING HOSPITALS AND UNCOMPENSATED CARE

Presented to the Pepper Commission
United States Bipartisan Commission on
Comprehensive Health Care

October 24, 1989

aamc

Association of American Medical Colleges / One Dupont Circle, N.W. / Washington, D.C. 20036 / (202) 828-0525

EXECUTIVE SUMMARY

Major amounts of uncompensated care are provided by this nation's hospitals and, in particular, teaching hospitals. In 1987, non-federal members of the AAMC Council of Teaching Hospitals provided 59% of all charity care. Similarly, teaching hospitals also provide major amounts of care to Medicaid beneficiaries. In 1987, COTH members reported 45% of all Medicaid gross revenues received by hospitals and accounted for 34% of all Medicaid discharges.

The existence of educational programs within teaching hospitals enables many of these hospitals to provide medical services to the uninsured. Salaried residents and supervising faculty are frequently the primary source of physician services for poor patients. In turn, caring for these patients provides medical students and residents with a broad and varied educational experience.

While the provision of some uncompensated care by teaching hospitals is nearly universal, the amount varies across hospitals. Higher levels of uncompensated care occur in large urban areas. For example, in 1987, approximately 40 COTH municipal hospitals--which accounted for 3% of total net patient revenues--furnished 28% of all charity care provided by U.S. hospitals.

Uncompensated care losses are becoming a major component in the creation of financial distress for many teaching hospitals. They can no longer shift the costs of caring for the uninsured to other patients, due to changes in third-party reimbursement, reduced health care spending, and limits on insurance coverage, and are therefore experiencing decreased revenues. Positive steps must be taken to address the needs of both the uninsured population and the teaching hospitals that treat them.

The Association of American Medical Colleges (AAMC) welcomes the opportunity to present this statement on the provision of health care to the poor and uninsured. The AAMC's Council of Teaching Hospitals (COTH) is composed of 440 federal and non-federal teaching hospitals. As major providers of health care services to the uninsured, the underinsured, and Medicaid recipients, teaching hospitals are acutely aware of the financial and other problems associated with the provision of uncompensated care. Teaching hospitals are increasingly concerned about their ability to finance the existing level of uncompensated care, let alone any increases that will be required in the future if the number of uninsured and underinsured individuals continues to grow. Therefore, the AAMC looks forward to this Commission's recommendations with great interest.

Definitions

To ensure a clear discussion of uncompensated care, the AAMC wishes, at the outset, to make some definitional distinctions between individuals who are uninsured and underinsured, between a hospital's charity care and bad debt, and between care that is uncompensated and unsponsored.

--Individuals who are **uninsured** have no health insurance at all, neither public nor private.

--Individuals who are **underinsured** have public and/or private health insurance that is inadequate in terms of depth or breadth: the insurance program may include uncovered services, service limitations, or heavy cost sharing, any or all of which result in individuals having out-of-pocket expenses which are too high in relation to their income.

--**Charity care** is care provided to individuals who are unable to pay.

--**Bad debt** results from providing services to patients from whom payment is possible but not made.

--**Uncompensated care** is the amount of free care provided by a hospital and is the total of bad debt and charity care.[1]

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[1] Because hospitals vary substantially in how they classify patients as either bad debt or charity, the two measures have traditionally been combined into a single uncompensated care measure.

--**Unsponsored care** is uncompensated care minus any offsetting state or local tax appropriations.

This statement will focus on the costs and consequences of uncompensated care--the effects felt by teaching hospitals in caring for the medically indigent, both uninsured and underinsured.

Teaching Hospitals and the Provision of Uncompensated Care

Knowledgeable health care providers are aware that the problem of the uninsured is significant, but perhaps none are more aware than teaching hospitals. The number of uninsured individuals increased from 30 million in 1980 to 36.8 million in 1986, although recent statistics suggest this number is now closer to 31 million [2]. Most have very modest incomes, but are in families exceeding the federal poverty threshold for their family size, thus not qualifying for Medicaid [3]. Moreover, the majority of the uninsured are employed, but work in jobs where health care coverage is not provided [4].

Major amounts of uncompensated care are provided by this nation's hospitals. In 1980, hospitals provided a total of $1.3 billion in charity care and deducted $3.3 billion in bad debt [5]. This compares to $3.5 billion in charity care and $6.8 billion in bad debt in 1987 [6]. Of the 1987 amounts, the 309 non-federal members of the AAMC's Council of Teaching Hospitals that responded to the AHA Annual Survey[7]--and which account for 7.5% of all non-federal short-term hospitals in the United States that responded to the survey--provided 59% of all charity care, or $2.1 billion, an amount that has more than tripled since 1980. In 1987, these hospitals also deducted $2.3 billion in bad debt [8]. These figures indicate that teaching hospitals, and particularly members of COTH, provide a very substantial portion of care provided to the uninsured and underinsured.

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[2] M. Eugene Moyer, "A Revised Look at the Number of Uninsured Americans," Health Affairs 8 (Spring 1989): 102-110.

[3] Individuals are considered to be poor when their family's annual pretax cash income is below a federally predetermined poverty threshold. In 1988, for the 48 continental states and the District of Columbia, an individual with income below $5770 and a family of three with income below $9690 were considered poor. (U.S. Cong., House Committee on Energy and Commerce, Medicaid Source Book: Background Data and Analysis, report prepared by the Congressional Research Service, 100th Cong., 2d sess., 1988, Committee Print 100-AA.)

[4] Moyer, "A Revised Look at the Number of Uninsured Americans."

[5] American Hospital Association, 1980 Annual Survey of Hospitals.

[6] American Hospital Association, 1987 Annual Survey of Hospitals.

While the provision of some uncompensated care by teaching hospitals is nearly universal, the amount varies across hospitals. Higher levels of uncompensated care occur in areas with a poorer population and poorer economic conditions--usually large urban areas. It is in these areas--locations with over a million population--that about half of COTH members are located. In turn, some of these hospitals, along with urban public hospitals not belonging to COTH, provide a disproportionate share of uncompensated care. For example, in 1987, municipal COTH hospitals, a small group of hospitals numbering less than 40, accounted for 3% of total net patient revenues, but furnished 28% of all charity care provided by U.S. hospitals [9].

The point here is that many people have the mistaken impression that the terms "teaching hospital" and "charity care hospital" are synonymous and that all teaching hospitals are in essence charity care hospitals. However, that is not the case--as indicated above, not every teaching hospital provides a vast amount of charity care. For example, a Florida study of teaching hospitals found that the charity care burden as a percent of gross revenues in these hospitals varied from 4.6% to 13.7%. One hospital, with 100 residents, had a 12.5% charity care burden, while another, with 126 residents, had a 4.6% burden [10]. According to the study, the critical factors in determining the share of charity care were location and location-related factors such as wage mix and payer mix. As a general rule, however, a hospital with a large charity care load is likely to be a teaching hospital, but not all teaching hospitals have large charity care loads.

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[7] Except where otherwise noted, statistics in this report regarding COTH members are for non-federal members of COTH only.

[8] American Hospital Association, 1987.

[9] American Hospital Association, 1987.

This is not to say that the existence of teaching programs--medical education--within a hospital is not an important factor in the provision of charity care. To the contrary, because of medical education programs, the hospital has salaried residents and in some cases supervising faculty able to provide medical services without fee-for-service payments. For poor patients, the resident becomes the primary source of physician services. However, this confounds the uncompensated care issue with respect to teaching hospitals in two ways. First, expenses for residents and supervising physicians are categorized as educational costs, even though they are also supporting physician services to poor patients. Second, while the hospital incurs these added costs, it is not credited with the savings that result from the absence of a fee-for-service physician. This is particularly important to remember when comparing teaching hospital and non-teaching hospital costs. The overlap of the educational and charity care issues is extensive because many teaching hospitals, located in urban centers, have established large clinics and primary care services to meet neighborhood needs. Their programs for burn, trauma, high risk maternity, substance abuse, and intensive psychiatric care, and the presence of advanced technology, attract patients having acute medical needs but unable to pay for their care.

Some critics assert that teaching hospitals **need** charity care patients in order to provide comprehensive medical education and that therefore the issues of charity care and medical education are inextricably linked. This view is true in part because of the number and variety of cases needed to carry out a broad educational curriculum, and because the poor often present cases in the more advanced stages of illness and with greater medical complexity. However, it is also true that this view reflects the historical fact that many early graduate medical education programs developed in municipal hospitals and in charity care wards of voluntary hospitals where the need by educational programs for patients complemented the need by hospitals for physicians. While today a number of educational programs are still located in hospitals and wards that serve a large number of charity care patients, many other programs are conducted in community hospitals that serve only a small number of these patients. The AAMC therefore believes that in discussing solutions to the indigent care problem, it is best to separate the issue of charity care from the issue of medical education and to address each individually. While these issues are sometimes present simultaneously, they are not necessarily interwoven and inseparable.

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[10] Policy Analysis, Inc., "A Comparative Analysis of Florida's Teaching and Research Hospitals," report prepared for the Florida Department of Health and Rehabilitative Services, 1988.

It should be noted that the VA health care system also serves an important role in the provision of uncompensated care by serving the health care needs of veterans who are uninsured and underinsured. Currently there are 172 VA medical centers--132 of which are affiliated with medical schools and are considered teaching hospitals. By law, 13 million veterans have categorical entitlement to VA hospital care [11]. A recent report indicated that about 12% of all veterans had no insurance at all, but even more importantly, 45% of veterans hospitalized in VA hospitals lacked insurance of any type. Another 21% of veterans hospitalized in VA hospitals had nonprivate insurance--Medicare, Medicaid, or military (CHAMPUS and CHAMPVA)--thus having the potential to be underinsured [12]. Since significant numbers of veterans using VA hospitals are uninsured and underinsured, the role of the VA in providing uncompensated care--and in reducing the burden of providing uncompensated care on other hospitals--must also be understood and included when addressing the uncompensated care issue.

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[11] Category A includes veterans having a service-connected disability, regardless of age, as well as those meeting a strict income or means test. Category B veterans, whose income is above the Category A cut-off but falls below a second income standard, are eligible for care on the basis of available space.

[12] Gronvall, John A., M.D., "Low-Income Veterans in the VA Health Care System," Health Affairs 6(Spring 1987): 167-175.

Medicaid

In addition to providing a substantial amount of charity care, teaching hospitals also provide care to many underinsured individuals, especially Medicaid recipients. Medicaid, enacted in 1965 to provide access to health care to the poor, is in 1989 utilized by only 40% of this country's poor, down from 53% 10 years ago. Cuts in the program over the past 8 years have totaled $4 billion, and while there have been some recent improvements in the program, they represent only 10% of what was cut [13]. Benefits and eligibility vary from state to state, so that accessibility to health care for low-income individuals largely depends on state of residence. Moreover, because Medicaid is a means-tested program and eligibility is dependent on enrollment in either the Aid to Families with Dependent Children program or the Supplemental Security Income program, individuals may suddenly find themselves without Medicaid should they no longer qualify for either of these programs. It is also true that states vary in the extent to which they have implemented optional programs for the medically needy.

Teaching hospitals are acutely aware of the problems associated with Medicaid. In 1987, COTH members accounted for 23% of all patient discharges but 34% of all Medicaid discharges. In addition, in 1987, COTH hospitals reported $7.6 billion in Medicaid gross patient revenues or 45% of that reported by all hospitals; 14% of all COTH hospitals gross patient revenues came from Medicaid, compared to 7% of non-teaching hospital revenues [14].

Medicaid reimbursement rates for many providers are low. A 1985 survey by the American Hospital Association comparing Medicaid per diem payments with per diem expenses found that Medicaid payments as a percentage of actual expenses ranged from 46.1% to 127%, with 32 of 42 respondents below 100% [15]. This underreimbursement often works as a disincentive for many providers to accept Medicaid recipients.

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[13] U.S. Congress, House Select Committee on Aging, An Assault on Medicare and Medicaid in the 1980's: the Legacy of an Administration, 100th Cong., 2d. sess., 1988, Committee Print 100-679.

[14] American Hospital Association, 1987.

Consequences of Uncompensated Care

Both hospitals and patients suffer because of uncompensated care. Because of the lack of insurance or underinsurance, individuals either may fail to seek needed care or wait until a condition has progressed to an advanced and more serious state to seek care. These individuals rarely have a personal physician and there is no continuity of care, often no follow-up or aftercare. Moreover, most of the uninsured use hospitals as their regular source of care, relying on the hospital outpatient department or emergency room for treatment. A Fairfax County, Virginia study found that 21% of uninsured families used the hospital emergency room as their "normal site of care," compared to 3% of Medicaid and privately insured patients [16]. That same report, in analyzing hospitalization rates for self-pay and privately insured patients for several conditions that should be preventable or controlled, found that the uninsured are three times as likely to be hospitalized for uncontrolled diabetes than the privately insured, and that they are more than two times as likely to be hospitalized for cervical cancer. An Indiana study of hospital charity care patients found pregnancy and childbirth, injury and poisonings, digestive system disorders, newborn aftercare, and mental disorders to be their primary diagnoses [17]--a hospital emergency room is not the most appropriate site of treatment for the majority of these conditions and ailments. Finally, a recent article in the Journal of the American Medical Association indicated that in one California study, babies whose parents lacked health insurance were about 30% more likely to die at birth or be born seriously ill than insured babies [18]. In sum, individuals' health and well-being suffer when they are not afforded regular and timely access to health care.

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[15] U.S. Congress, House Committee on Energy and Commerce, Medicaid Source Book: Background Data and Analysis, report prepared by the Congressional Research Service, 100th Cong., 2d sess., 1988, Committee Print 100-AA.

[16] Lewin/ICF, "Health Care for the Medically Indigent of Fairfax County," report prepared for the Fairfax County Board of Supervisors, 1988.

[17] U.S. Congress, House Committee on Education and Labor, Health Insurance and the Uninsured: Background Data and Analysis, report prepared by the Congressional Research Service, 100th Cong., 2d. sess., 1988, Serial 100-Z.

For teaching hospitals, uncompensated care losses are becoming a major component in the creation of financial distress--the combination of charity care and Medicaid "undercompensation" are having serious adverse effects on some teaching hospitals. In the past, teaching hospitals have generally provided care to all regardless of ability to pay. Uncompensated care was financed through "cost-shifting" (subsidizing charity care by increasing the prices charged to other patients), government subsidies, and philanthropy. However, changes in third-party reimbursement, reduced health care spending by federal, state, and local governments, and limits on health insurance coverage have combined to squeeze hospital revenues by increasing need for charity care but reducing the resources to finance it.

The increase in competition has also made it more difficult to shift costs. For example, hospitals may negotiate with insurers to provide "discounted rates," below standard charges, in order to be price-competitive and retain patients. This practice limits the hospitals' ability to generate extra revenue from paying patients. Moreover, teaching hospitals are already more expensive than non-teaching hospitals, putting them at a disadvantage before the burden of uncompensated care is even added. Financial losses from charity care and bad debt may be compounded if the hospital's Medicaid reimbursement is below actual care costs.

All these events--which are compounded by continuing federal efforts to reduce Medicare payments to teaching hospitals--have resulted in decreased revenues for teaching hospitals. According to an analysis done by the AAMC, 65 COTH academic medical center hospitals experienced a marked decline in their financial position in 1988, as measured by Medicare PPS margins[19] and total margins. In the early years of PPS, this group of hospitals experienced relatively high Medicare margins; however these dropped to 5.3 percent in 1988. While only two of the 55 reporting hospitals had negative margins in 1986, 19 of the 65 reporting 1988 data had margins of less than zero. The combination of a low update factor and a reduction in the indirect medical education adjustment from 8.1% to 7.7% will likely produce many more hospitals with Medicare margins near zero for 1989. Total margins for the 65 hospitals, which include revenues and costs from all patients and endowment and investment income, were in 1988 one-half of their 1986 level, falling from 6.2 percent in 1986 to 3.1 percent in 1988 [20].

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[18] Paula Braverman, MD, et al. "Adverse Outcomes and Lack of Health Insurance Among Newborns in an Eight-County Area of California, 1982-1986," Journal of the American Medical Association 321 (August 24, 1989): 508-513.

Reduced revenues produce financial stress on teaching hospitals, which must then find ways to ease the burden of uncompensated care. One way is to limit the amount of uncompensated care provided. Hospitals could achieve this by, for example, not accepting non-paying patients for non-emergency care, setting a fixed annual budget for uncompensated care, developing a priority system for nonemergency care, requiring a downpayment for elective admissions, or reducing hours or staffing for outpatient and emergency care. Teaching hospitals could also discontinue or reduce programs that traditionally draw a high volume of uncompensated care patients, such as substance abuse and social service programs. Teaching hospitals, however, because of their historic commitment to provide care to all, are reluctant to take any of these actions, but may be forced to in the near future. For example, on August 28, West Virginia University Hospitals in Morgantown began to ration care to the poor by setting a monthly quota for admissions of non-emergency charity care patients. By doing this, the hospital hopes to reduce its uncompensated care burden by $5 million. However, it means that 500 poor people will be turned away by the hospital each year.

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[19] PPS margin is defined as PPS revenue (DRG payment, disproportionate share payment, IME payment, and outlier payment) less Medicare inpatient operating costs, divided by PPS revenue.

[20] Association of American Medical Colleges, "Positions on the Administration's FY 1990 Budget Proposals to Reduce the Indirect Medical Education Adjustment and Direct Medical Education Payments," presented to the Subcommittee on Health, House Committee on Ways and Means, April 11, 1989.

Recommendations

This statement has documented the large volume of services that teaching hospitals provide to those individuals unable to pay for hospital services. This is evidenced by:

--major commitments to charity care;

--high bad debt expenses; and

--care for a large number of Medicaid patients.

The AAMC believes positive steps must be taken to increase the number of insured individuals. Admittedly, the AAMC is not in the field of public finance policy and believes it is up to others to come up with the most appropriate solutions for providing health insurance coverage to more people. However, the AAMC is concerned that efforts in this area not be delayed and that some form or forms of explicit funding for uncompensated care be implemented in order to ease the financial stresses being felt by teaching hospitals.

The AAMC does support two general approaches to help resolve the situation. The first is the expansion of the Medicaid program to provide more services to a broader scope of individuals. For example, the Ad Hoc Committee on Medicaid of the Health Policy Agenda of the American People has developed recommendations to expand Medicaid that include a uniform national income eligibility standard and a standard benefit package [21]. The second is mandated employer-provided insurance. Since most uninsured individuals are employed, mandated employment-based insurance would significantly decrease the problem of the uninsured.

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[21] See, "Including the Poor: The Final Report of the Ad Hoc Committee on Medicaid of the Health Policy Agenda of the American People." February 1989.

AGE AND YOUTH IN ACTION
GRAY PANTHERS
PROJECT FUND

STATEMENT OF
GRAY PANTHERS PROJECT FUND
SUBMITTED TO
THE PEPPER COMMISSION
Chairman John D. Rockefeller, IV
on January 16, 1990

Washington D.C. Office of the Gray Panthers Project Fund
1424 16th St., N.W., Lower Level, Washington, D.C. 20036 (202) 387-3111

Mr. Chairman and Members of the Commission:

The Gray Panthers are an intergenerational organization of over 70,000 members - age and youth in action to combat age discrimination and all forms of prejudice, and to promote peace, health and social and economic justice. We will be celebrating our 20-year anniversary this year on May 10 to 13 in Washington, D.C. at the National 4-H Center, and invite the Commission members to join us in the celebration.

The National Health Task Force of the Gray Panthers commends your efforts to address the complex issues concerning our health care system. We have always recognized the need for a national health program in the United States, and have been a steadfast supporter of Rep. Ronald Dellums' bill for a national health service. We do not believe it is necessary to repeat the litany of ills in our country's health care system - you are well aware of the problems of the uninsured, infant mortality rates, the inability of disabled and elderly people to get adequate long term care, and the greater rates of illness and deaths among poor and minority people. But we do wish to add an item to that litany. The World Health Organization emphasizes that the MAJOR determinant of a person's health is his or her standard of living, while prevention is second in importance, and the availability of medical care is only third. Because disparities in wealth in the U.S. have increased greatly in the last decade, we have more people living in poverty and more suffering from chronic hunger. And we are witnessing in horror the new and growing problem of homelessness.

We predict, therefore, that the overall health status of the American people will get worse before it gets better. Therefore, our first recommendation to the Commission with respect to national HEALTH policy is that Congress must act to improve the nation's health status by improving the standard of living for our poor citizens. That means affordable housing for everyone, and it also means ending the pain of hunger and hopelessness - which has become pervasive in our rural areas and inner cities.

Secondly, national health policy must rediscover the value of prevention. Medicare is a perfect example of an irrational program which rewards the costliest, least cost-effective component of any health care system: its acute care services. All the while, it disdains to pay the cheapest, most cost-effective component: public health and preventive services. The most recent example of that irrationality was in November, when Congress took mammography out of Medicare and replaced it with pap smears, as though preventive services are interchangeable commodities to be horse traded.

Thirdly, we want to inform you about the delegation of Gray Panthers that visited the health care system in Quebec and Ontario in April, 1985 at the invitation of Canadian health officials. We discovered the fascinating history of how that program evolved, which is instructive to us now. Canada was not impatient -- it did not try to do it all at once. It created its national health insurance program in stages. And not the endless little increments and band-aids that characterize our planless approach. First, Canada established a universal hospital entitlement program, and then a universal medical program, and then at other stages folded in nursing home care, preventive services, and so forth.

Therefore, the first lesson we believe should be learned from Canada is that a complete national health program does not have to leap from your pens all at once. There are many good arguments for making a beginning toward a comprehensive, universal health system by starting with a portion of the solution in staged increments, and not by attempting to do it all at once.

The next question, of course, is where to begin. Again, it may be helpful to look to the Canadian example. Canada started with universal hospital care for very good reasons in terms of its history and circumstances. After World War II, hospitals' physical plants were in poor shape, the private sector could not help the situation, and the insurance industry did not have the firm control over financing that this country experiences with respect to most medical services. So there was a need for public financial aid, and at the same time, little opposition from powerful interests. Therefore, universal hospital care became the starting point in Canada.

In the United States at this time, where do we see less insurance penetration in medical services financing, and at the same time an almost universal recognition of a serious need? The answer is twofold and intergenerational: in maternal and infant care and in long term care. If we are to make a beginning toward enactment of a national health care program, let us begin where, as in Canada, there is a widely acknowledged need, and at the same time, comparatively little entrenched opposition and disruption. Linking maternal and infant care and long term care in a single step forward toward universal coverage avoids intergenerational strife and accomplishes goals in areas of broad Congressional concern. Instead of inching forward year by year with tiny increments of coverage, we could replace all the categorical governmental programs, states' mandated benefits, spotty insurance benefits for pregnant women, etcetera, with a universal entitlement. At the same time, the inadequate portions of long term care in a plethora of programs -- block grants, Medicare, Medicaid, VA programs, negotiated medical contracts, and such, could be replaced with a single, rational long term care program. If the states' current level of financial commitment were assured, as well as current federal expenditures, then the additional costs of a universal program would not be excessive when spread over the entire population in broad-based revenue support.

The Gray Panthers delegation was so impressed with what it saw in Montreal and Ottawa in 1985 that we vowed to tell the American public that the best kept secret in our country was the Canadian health system. We are proud to say that we take some of the credit for the great surge of interest and admiration in the United States for Canada's achievement. We note that the American Medical Association has allocated two and a half million dollars for a campaign to besmirch the Canadian health system, but predict that its effort will not succeed because Canada is our neighbor and its accomplishment is manifest.

Canadians enjoy universal coverage of all major components of high quality medical care at a cost 25% less than in the U.S. Although medical services and supplies are expensive, they have achieved cost containment largely by eliminating the burden of the private insurance industry intrusion health care, and establishing a single source of payment for the services. In no other way can we achieve cost containment and strive to reach the goal of universal entitlement.

Finally, we want to inform you of OUR Commission. The Gray Panthers held a series of some 20 public hearings throughout the United States, beginning at the Shiloh Baptist Church in Washington, DC in December, 1987 and ending in Sarasota, Florida in 1989. You may know that Barbara Jordan chaired the hearing in Austin, Texas. People spoke out regarding their difficulties gaining access to medical services. We have convened a National Commission of medical care experts to analyze action steps to be undertaken to address the issues uncovered. Our Commission's report will be issued in the Spring of 1990. We trust that it will contribute to the dialogue concerning national health policy options, and will help to build momentum toward adoption of a rational, comprehensive, universal, high quality health care system, whose inevitability appears to be less and less in doubt.

American Association for Continuity of Care
1101 Connecticut Avenue, N.W., Suite 700 • Washington, D.C. 20036 • (202) 857-1194

October 20, 1989

John D. Rockefeller IV
Chairman, The Pepper Commission
United States Bipartisan Commission on
Comprehensive Health Care
140 Cannon House Office Building
Washington, DC 20515

Dear Senator Rockefeller,

On behalf of the 800 members of AACC, I want to thank you for the opportunity to present the following information. Our members include multidisciplinary professionals, primarily nurses and social workers, who work in the arena of health care delivery. Our main focus is on the issue of continuity of care which includes **access to health care** at all levels. This necessarily encompasses long term care.

The Pepper Commission's "Options Analysis Paper" outlined two broad concepts for dealing with the problem areas. The statement that the "options can be combined to develop a comprehensive plan" is very significant in that it reflects the need for such a plan.

The basis of practice of a continuity of care professional, be they called "Discharge Planner" or "Continuing Care Specialist", is that of assessing the needs of a patient and evaluating the available resources to meet those needs. The categories of needs range from post-hospital nursing care to homemaker services.
The range of available resources which must be investigated include family availability, skilled service availability, Medicare resouces, private insurance coverage or private funds. The Discharge Planner takes the identified needs of the patient and the available resources, and makes the best possible match of resources to needs.

In an effort to support an understanding of the fragmentation of not only the delivery of care, but the fragmented system for access to care, the following steps describe access problems for a sample patient.

1. Entry into the health care system: a patient enters the hospital through the emergency room. The necessary acute services are given and the patient is medically ready for discharge. An ongoing assessment of the needs of the patient/family is done and the available resources necessary to meet those needs are evaluated. •Options of where the patient/family needs can be met and the funding sources of those options are investigated.

2. Discharge to a rehabilitation facility: the next step for this patient is a transfer to a rehabilitation facility so that the patients potential for independent living can be maximized.

•Options for the next level of care are identified and funding sources are investigated.

3. Discharge to a skilled nursing facility: following rehab services the patient is transferred to a facility where ongoing rehabilitation and continued skilled care are provided.

•Options for the next level of are are identified and funding sources are again investigated.

4. Discharge to home with in home services: from the nursing home the patient is discharged to home and home care services are provided by a home care agency.

5. Discharge from home care: following attainment of goals, or exhaustion of benefits, the patient is discharged from services.

•There are very few options available at this level of care. The beneficiary is essentially out of the health care system until another acute care episode occurs.

In assessing the needs of patients, at all levels of care, it is not uncommon to be forced into a situation in which we must assess the need to fit the benefit. This hampers both individuality of care planning and continuity of care.

All of the time this patient is in the system, there is not one person/agency who is tracking the delivery of care and/or the spending of dollars for this care.

This patient's bills for care have been reviewed by at least three Medicare Fiscal Intermediaries. One for the hospital, one for the nursing home and one for home care. This patient's care has been evaluated by several persons, but not one person/agency is aware of the total care needs or money spent on total care delivery.

In the "Report to the Chairman, Subcommittee on Health, Committee on Ways and Means, House of Representatives" published by the United States General Accounting Office in May of 1988, Medicare: Improving Quality of Care Assessment and Assurance, GAO/PEMD-88-10, the following statement is made:

> The medical review activities of carriers, intermediaries and PROs with respect to quality of care are virtually independent...They independently build profiles of provider or practitioner performance to identify possibly problematic pattern of service delivery or patient outcomes. Profiling results are not routinely shared among PROs, carriers, or intermediaries reviewing care in the same geographic areas... If a patient qualifies for Medicare post-hospital services and the intermediary suspects that the hospital discharge may have been premature, HCFA is notified. But, if posthospital coverage is denied by Medicare, there is no mechanism, other than beneficiary complaints, for notifying either HCFA or PROs about possibly inappropriate or premature discharges..."(p. 3)

The care needs described is comprehensive care, which includes medical care, skilled nursing and therapies, personal care and other services necessary for the patient to be maintained in their family environment.

The delivery of care to a relatively simple case is very complex and requires several layers of review, loss of confientiality, and loss of control of dollars that are spent.

The need for one source for funding and of monitoring of care is critical. The management of care delivery is missing. The management of dollars to pay for care is not being done in a manner that provides for assessing the need and then using the benefit in the most cost effective way. The predetermined benefit is running the system, not the identified needs of the patient.

The need for management of care of our beneficiaries, one "case" at a time is critical. The current health care delivery lanquage has begun to see terms like "case management", "care management", "benefit management" and several other combinations of key words.

The AACC proposes a system in which there is one person/agency who can coordinate, monitor and evaluate the delivery of care to patients in all settings in which the patient is receiving health care services.

We are proposing that the person with the authority to control the benefit allocation be a health professional who has knowledge of assessing needs of the individual patient and of available resources to meet those needs.

The system will not be easy to design, but starting with the focus of one central source of funding, authority to fund identified benefits by a health professional, and managing all health care delivery on a patient by patient basis is a place to begin.

As a nation we have tried to address the issue of spending too much on health care with fragmented results. In an article which appeared in Scientific American Vol 224, No. 4, April 1971. "Government Investment in Health Care", Irving J. Lewis, makes the following opening statement:

> "The problem of providing satisfactory medical service to all the people of the United States at costs which they can meet is a pressing one. At the present time, many persons do not receive service which is adequate either in quantity or quality, and the costs of service are inequitably distributed. The result is a tremendous amount of preventable physicial pain and mental anquish, needless deaths, economic inefficiency and social waste.

> Furthermore, these conditions are largely unnecessary. The United States has the economic resources, the orgainzing ability and the technical experience to solve this problem".

The most interesting part of this quote is that it was not written in 1971, but was from the final report of the Committee on Costs of Medical Care, dated October 31, 1932, and signed by Ray Lyman Wilbur, President Hoover's Secretary of the Interior.

We urge you to consider our proposal for one funding system for health care, no matter where the patient receives the care, and that this system be managed by a health professional who can work with our beneficiaries, one case at a time. This will lead to less fragmentation of care and we will be able to design the benefit to meet the needs of the patient in a cost effective way.

We in the American Association for Continuity of Care welcome the opportunity to provide additional information and counsel to the members of The Pepper Commission and Staff members on this very important issue.

Sincerely yours,

Jackie Birmingham, RN, MS
Chairperson, Government Relations
President-Elect, 1990

cc: Marilyn Burlenski, President
Mike Hamm, Executive Director

GOVERNMENT RELATIONS
Kenneth F. Melley, Director

NATIONAL EDUCATION ASSOCIATION • 1201 16th St., N.W., Washington, D.C. 20036-3290 • (202) 822-7300
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ROXANNE E. BRADSHAW, Secretary-Treasurer

STATEMENT OF THE
NATIONAL EDUCATION ASSOCIATION
BEFORE
THE BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

WASHINGTON, D.C.
OCTOBER 24, 1989

Mr. Chairman and Members of the Commission:

Through repeated action of its Representative Assembly, the National Education Association has recognized the growing crisis in access to quality, affordable health care. More than 37 million Americans have no health insurance at all, even though two-thirds of this group are employed. Millions more are underinsured. Congressional and private studies show that at least one of every five citizens is at risk because of economic or other barriers to good health care.

Teachers and other school employees are no better off than the rest of the population when it comes to health care. There are substantial differences in insurance coverage state to state, even district to district within a state.

School personnel see the results of a fragmented, inefficient health care system in their everyday encounters with students and their families. Undiagnosed and untreated illness is common among students, especially from lower and lower-middle income families. Many students lose time from school helping to care for a loved one who is too sick to work or too poor to afford a doctor visit or a hospital stay.

And yet the United States will spend a staggering $550 billion on health care this year -- about 12 percent of Gross National Product, more than any other industrialized nation. In recent testimony before the Congressional Joint Economic Committee, a panel of distinguished health specialists said Americans' health. judging by death, illness, and infant mortality statistics, is no better and in some cases worse than in European nations, which spend a far smaller share of GNP on health care.

Former HEW Secretary Joseph Califano says the nation is wasting at least $125 billion a year on needless surgery, empty hospital beds, and over-costly treatment plans. Part of the mounting cost problem is the lack of uniform, sensible quality control in medical practice. Another major contributing factor is inadequate preventive care. Although well-baby care is increasing, school health services -- potentially the most efficient preventive care system -- have been cut drastically as school districts try to improve the instructional program under tight budget constraints.

Is there a solution? NEA's Representative Assembly has proposed enactment of a universal health care plan, and Congress has begun to move cautiously toward it. Last year it passed a catastrophic insurance bill to expand protection of the elderly and disabled, although it rejected Claude Pepper's compassionate bill to provide long-term home care for the chronically ill elderly, disabled, and children. The acrimonious climate of this year's debate over catastrophic coverage should not deter Congress from making further progress in dealing with critical health needs.

But the need for a sensible national health care policy will not be met by such incremental measures. NEA urges the passage of a program that would be universal, comprehensive, cost-effective, and simple to administer. Each of these criteria can be met in a quality program administered at the state level under broad federal guidelines.

Following are basic criteria for a sensible health care program, as outlined in the Health Security Partnership legislation drafted by the *Committee for National Health Insurance*, a national coalition in which NEA has participated for 15 years.

Universality

Every American, regardless of age, would be automatically enrolled in the program. Each person covered by Social Security would receive a medical insurance card. Those who do not have an insurance card would receive one after the first time they visit a doctor or a hospital for diagnosis or treatment. Experience in other countries shows that more than 95 percent of the population would be enrolled very quickly under this procedure.

Comprehensiveness

As in the Canadian and other models, the program would provide coverage of all necessary medical procedures, including mental health treatment. There would be no exclusion of preexisting conditions. Medicare and Medicaid would be part of the system, at least initially. Because of cost, long term care and prescription drug coverage would have to be phased in, but the savings under an efficiently run program would not delay such coverage for more than a few years.

Cost Effectiveness

Because there would be basically one nationwide risk pool or statewide risk pools, the insurance cost would be lower than it is now for the thousands of plans that include relatively small groups of people. The costs of competing sales forces, duplicate claims forms, and wasteful promotional efforts would be eliminated.

All participating health care providers would have to negotiate fees on a prospective budgeting basis, year to year. The federal government and the states would be expected to maintain their plans under costs equal to or less than the previous year's increase in the costs of personal health services. Under a state-administered plan, there would be provision for regional differences in charges. The state's program standards could also include mandatory assignment, a requirement that the insurance reimbursement would have to be accepted by the doctors and hospitals as payment in full.

Quality control standards would help reduce costs in several ways. States would review current and projected use of hospital beds, the location of skilled nursing facilities and high technology medical equipment, the availability of trained personnel in remote areas, training standards for medical personnel, peer review, and input from consumers.

Administrative Simplicity

Under a federal-state partnership approach, the need for elaborate reimbursement forms and administrative complexity would be eliminated. Patients would simply present their medical cards when visiting a doctor or hospital. The prospective budgeting payment system would compensate the health care provider directly, saving untold thousands of paperwork hours for patients, providers, insurers, and government agencies.

Although it would take some time to untangle the administrative process now in place under Medicare and Medicaid, the health care system would soon be free to use its time and talent to solve human problems rather than bureaucratic snarls.

The Politics of Health Insurance

For many years the debate over a national health care plan has been shaped by the perception that such a plan would be "socialized medicine." What NEA proposes is not a federal takeover or the creation of a national health service. Rather, the proposed plan would build on the strengths of American medical technology and utilize the mechanisms of private insurance, with joint federal-state financing.

Historically, Congress has been reluctant to take on the insurance industry and various health care providers on the question of financing health care through a national plan. But the opposition to a universal plan is crumbling under the weight of administrative overload, the skyrocketing cost of malpractice insurance, and the increasing awareness of the public that it is not getting its money's worth from insurance premiums and taxes that pay for health care.

With the passage of a universal coverage bill in Massachusetts and the consideration of such programs in other states, the climate for productive debate on the issue is better than it ever has been.

Nonetheless, there will be opposition to a national health care plan. The nonexistent dragon of "socialized medicine" will be put on display. Opponents will say it's impossible to control costs, citing the fact that under present arrangements medical cost inflation far exceeds the general cost of living index. A national program meeting the criteria described above will put an end to the senseless escalation of health care costs.

NEA urges the Pepper Commission to make access to quality, affordable health care a prime issue in its deliberations. There are no valid or supportable arguments against the establishment of health care as a right, as a national priority, as a rational goal.

4

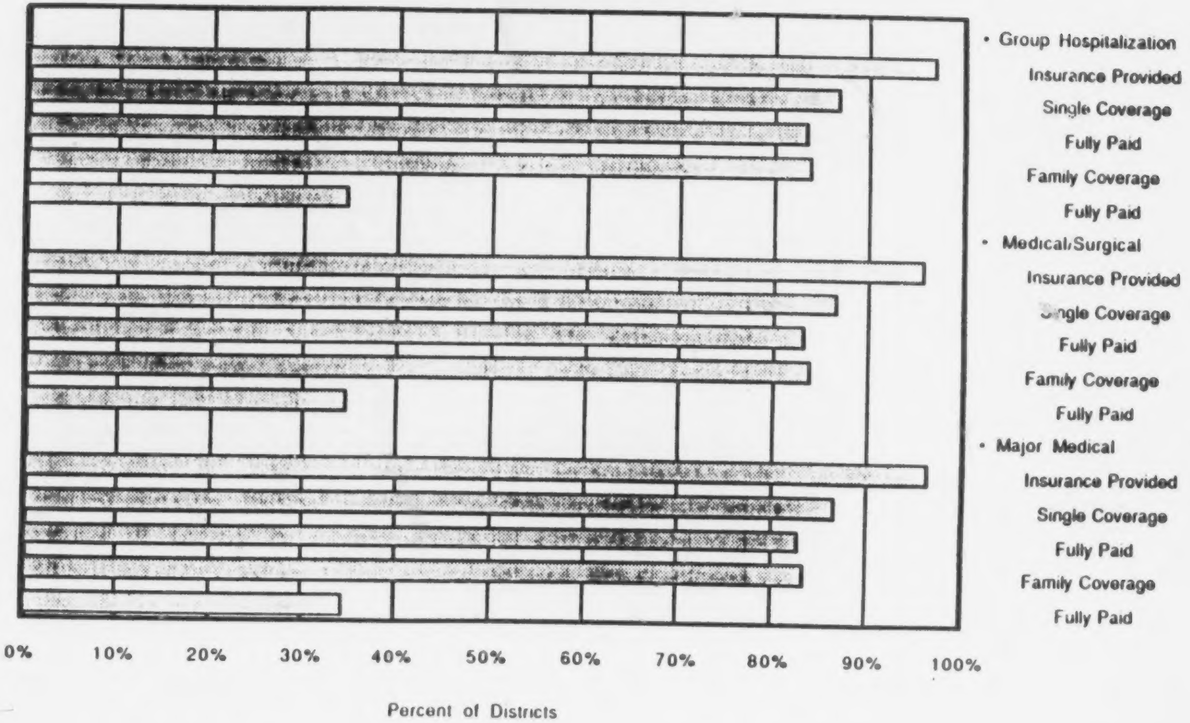
ATTACHMENTS

The following pages summarize public school employee health benefits, as reported in **Fringe Benefits for Teachers in Public Schools, 1987-88** (Educational Research Service, Arlington, VA).

Chart 1

HEALTH INSURANCE PROVIDED BY DISTRICT: Part 1

Group Hospitalization, Medical/Surgical and Major Medical for Teachers in Reporting School Districts

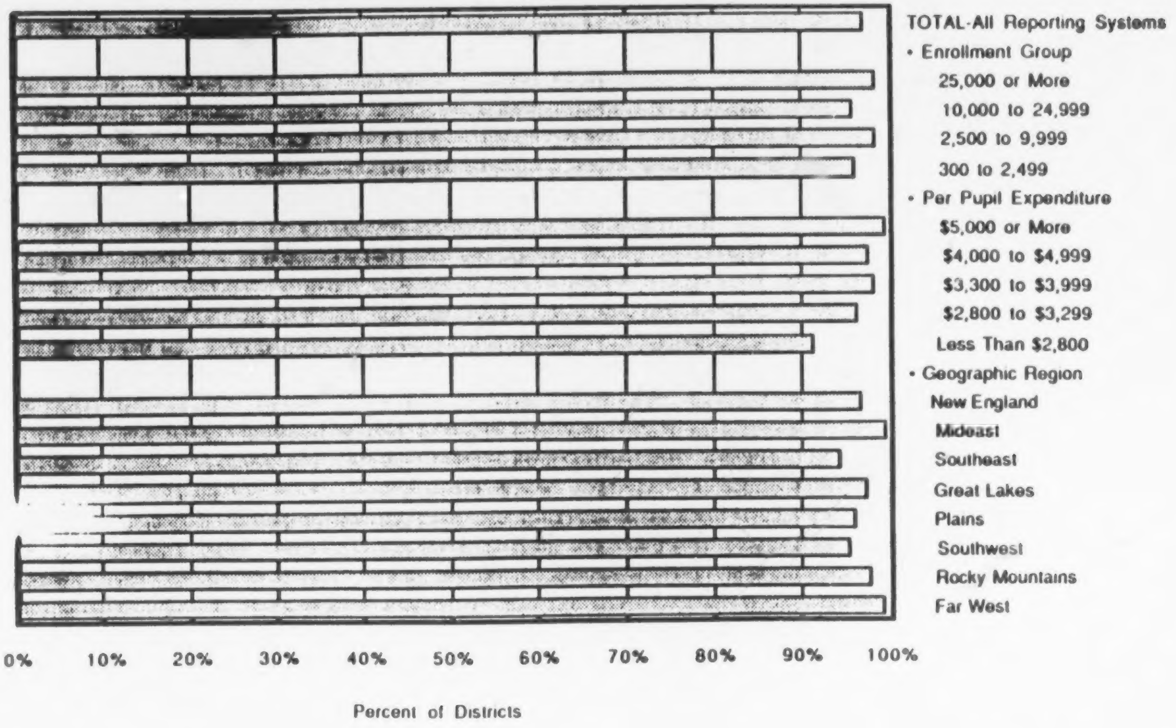


Reference Tables 18 and 19

Chart 4

COMPARISON OF GROUP HOSPITALIZATION COVERAGE PROVIDED:

Total, by Enrollment Group, by Per Pupil Expenditure Group and by Geographic Region for Teachers in Reporting School Districts

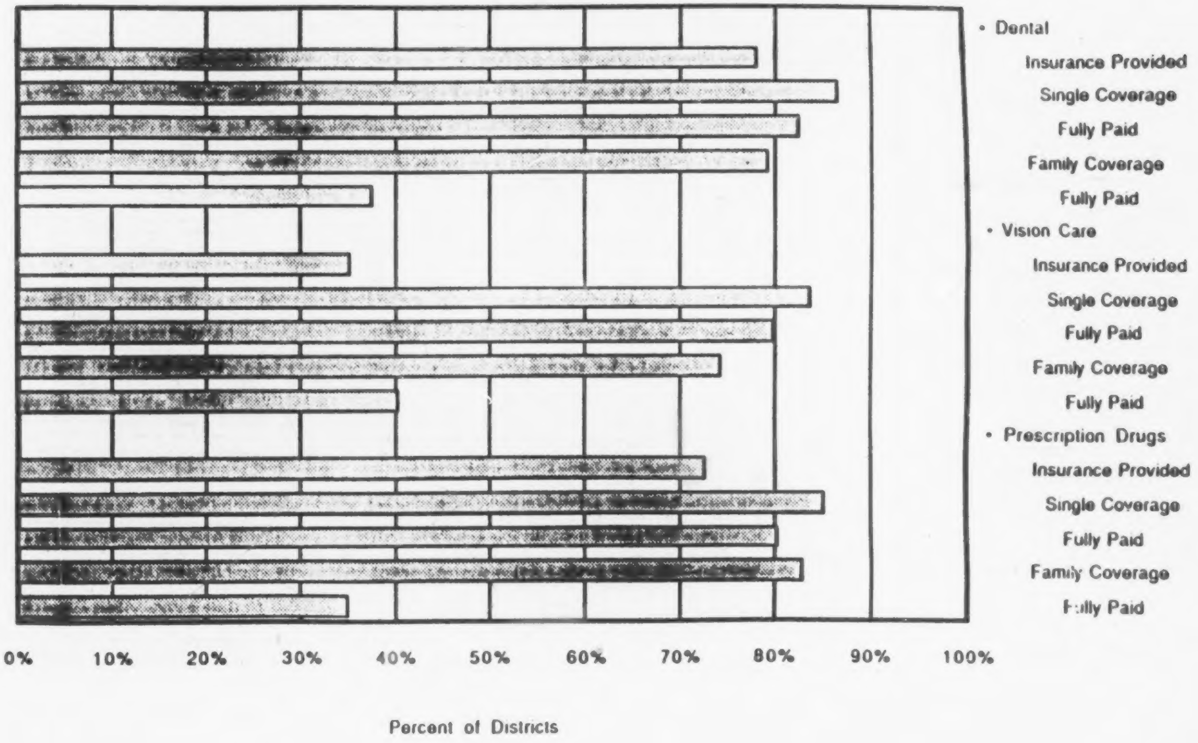


Reference Tables 5, 18 and 19

Chart 2

HEALTH INSURANCE PROVIDED BY DISTRICT: Part 2

Dental Care, Vision Care and Prescription Drugs
for Teachers In Reporting School Districts

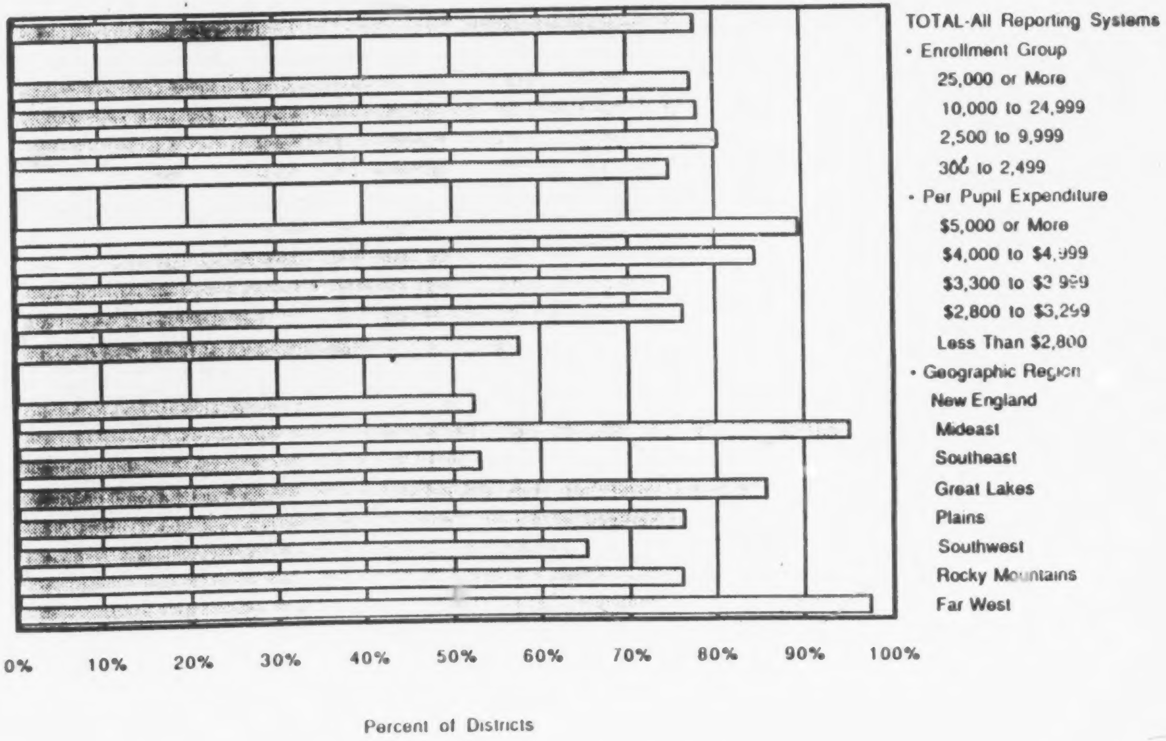


Reference Tables 18 and 19

Chart 7

COMPARISON OF DENTAL CARE COVERAGE PROVIDED:

Total, by Enrollment Group, by Per Pupil Expenditure Group and by Geographic Region for Teachers in Reporting School Districts



Reference: Tables 5, 18 and 19

AAMFT
American Association for Marriage and Family Therapy

November 14, 1989

The Honorable Jay Rockefeller
U.S. Bipartisan Commission on
Comprehensive Health Care
140 Cannon Building
Washington, D.C. 20515

Dear Mr. Chairman:

On behalf of the American Association for Marriage and Family Therapy (AAMFT), I appreciate having the opportunity to make recommendations to the Pepper Commission regarding improving access to health and mental health care and the development of a national long term care strategy.

This letter will provide you with background information on the American Association for Marriage and Family Therapy (AAMFT) and the discipline of marriage and family therapy, concluding with three broad recommendations for the Commission which are applicable to the debate on both general health care delivery improvements and the development of a long term care system.

AAMFT - ORGANIZATIONAL BACKGROUND

AAMFT is the national professional association of qualified practitioners of marriage and family therapy. Founded in 1942, AAMFT has more than 16,000 members nationwide and divisions in almost every state. For more than 45 years, AAMFT has been involved with the problems, needs and changing patterns of marital and family relationships. The Association works to increase understanding, research and education in the discipline of marriage and family therapy, and to ensure that public needs for necessary marriage and family therapy services are met by practitioners of the highest quality.

DEFINITION OF MARRIAGE AND FAMILY THERAPY

Marriage and family therapy, as a distinct discipline comprised of a distinct group of mental health professionals, has been emerging since the early 1940s. Marriage and family therapy is defined as the diagnosis and treatment of mental and nervous disorders within the context of marital and family systems. The practice of marriage and family therapy primarily regards psychopathology and dysfunction from the perspective of the family system, rather than from an assessment of intrapsychic problems or conflicts. It is characterized by the view that an individual experiencing the symptoms of a mental or nervous disorder is part of a larger system and, regardless of the eventual intervention modality, that larger system is essential both in evaluating the etiology of the symptom and in treatment. Consequently, treatment from a marriage and family therapy perspective involves, among other goals, the modification of the behaviors and the structures of the family system. Therefore, treatment usually involves intervention with all or some of the family members.

Our increased understanding of the relationship between marital and family dysfunction and serious mental and emotional disorders, disorders related to aging, substance abuse, eating disorders, disorders of childhood and adolescence, and other forms of psychopathology have contributed to the prominence of this discipline. In fact, it is rare today to treat either in-patients or out-patients with many of these disorders without attention to the family and the dynamics of the family system.

Marriage and family therapists are increasingly receiving recognition in both the public and private sector:

-- Marriage and family therapists have been reimbursed for their services by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) since 1966.

-- Congress amended the Public Health Service Act in 1988, such that marriage and family therapy is now officially recognized as one of five core mental health professions, the others being social work, psychology, psychiatric nursing and psychiatry.

-- Several pieces of federal legislation have been introduced in 1989 in recognition of the important role that marriage and family therapists have to play in providing mental health services to American families. Senator Daniel Patrick Moynihan (D-NY) recently introduced S. 1591, the Community Mental Health Services Act, to provide direct Medicare reimbursement for the services of marriage and family therapists, clinical social workers and psychiatric nurses practicing in Community Mental Health Centers. This legislation was developed to increase access to marriage and family therapy and other necessary mental health services for elderly Americans living in rural areas and in poor, underserved urban areas. In addition, Congresswoman Mary Rose Oakar and Senator Barbara Mikulski have introduced legislation (H.R. 211/S. 1048) to include marriage and family therapists as independent providers under the Federal Employees Health Benefits Program (FEHBP), the nation's largest health insurance program.

-- In recognition of the growing importance of the discipline of marriage and family therapy to our nation's health care system, AAMFT received a contract in 1989 from the U.S. Alcohol, Drug Abuse and Mental Heath Administration (ADAMHA) for extensive technical assistance in the development of a family therapy "track" of workshops for a conference on the treatment of adolescents with substance abuse and mental health problems. The October 2 - 4, 1989 conference, which was mandated under the Anti-Drug Abuse Act of 1988, was attended by more than 1350 state alcohol, drug abuse, and mental health administrators from across the nation.

ADAMHA has also contracted with the American Association for Marriage and Family Therapy for the development of a monograph of the conference and for a data base of family therapy experts who will be available to state administrators for consultation on transforming state agencies to incorporate a "family focus" in implementing substance abuse, mental health, foster care and other services.

-- To date, four states -- California, Florida, Nevada and Utah -- have enacted freedom-of-choice legislation requiring the direct recognition of marriage and family therapists (in California the state regulated title for marriage and family therapists is "Marriage, Family and Child Counselor" or MFCC). In these states, licensed/certified marriage and family therapists routinely and consistently are reimbursed directly by insurance plans which fall under the jurisdiction of state insurance laws and regulations. In addition, it is common for marriage and family therapists in these states also to be reimbursed directly by the self-insured employee benefit trust health plans that come under the jurisdiction of the federal ERISA statute.

-- Finally, in recent months, several large national Employee Assistance Programs (EAPs) have worked cooperatively with AAMFT to ensure that qualified marriage and family therapists are routinely and consistently included within health benefit programs. We believe that this is further evidence of the acceptance and importance of marriage and family therapists within the developing health care delivery system.

At present, 20 states license or certify marriage and family therapists: Arizona; California; Colorado; Connecticut; Florida; Georgia; Maine; Massachusetts; Michigan; Minnesota; Nevada; New Jersey; North Carolina; Oregon; Rhode Island; South Carolina; Tennessee; Utah; Washington and Wyoming. In the past three years, nine states have enacted regulatory laws for marriage and family therapists, evidence of a powerful trend toward state recognition of the discipline and the growing need for well-qualified providers.

RECOMMENDATIONS

AAMFT has three broad recommendations for the Pepper Commission:

1) **Mental health care, including marriage and family therapy, is an integral component of a comprehensive, effective health care delivery system. As such, the provision of mental health services, including marriage and family therapy, must be a part of the Commission's recommendations on both health care system access improvements and long term care. Further, AAMFT recommends that all qualified mental health professionals, including marriage and family therapists, be recognized as integral providers of these services.**

Millions of Americans require mental health care, including marriage and family therapy, for the treatment of mental and emotional disorders each year. As we have learned more about the social and behavioral antecedents of many costly medical illnesses, including heart disease, alcoholism, drug abuse, stress-related diseases, AIDS and other diseases, the services provided by qualified mental health professionals, including marriage and family therapists, are recognized as essential elements of an effective health care system.

Regarding the cost of these services, a study conducted by the Federal Office of Personnel Management (OPM) in 1986 affirmed the vast and widely accepted empirical literature in health policy and economics which suggests that a "cost-offset" phenomenon exists for mental health coverage. This phenomenon refers to the fact that the use of traditional and expensive medical services is found to decrease when appropriate mental health services are included within health benefit plans. The provision of mental health services, including marriage and family therapy provided by marriage and family therapists and other qualified mental health professionals, contributes to the "cost-offset" effect. Numerous studies show a decrease from 5% to 80% in medical service use following appropriate and well-managed mental health treatment. In fact, this well documented phenomenon in health benefit plan design and management has been thoroughly researched, with significant support from the Department of Health and Human Services' Alcohol, Drug Abuse and Mental Health Administration, specifically from the National Institute on Mental Health. Further, this cost-offset phenomenon has been found to exist in studies analyzing data from Federal Employee Health Benefit Program plans, both as cited in the OPM study and in several other empirical studies.

In particular, AAMFT recommends that marriage and family therapists, as well as other mental health professionals who have received training in marriage and family therapy, as have all Clinical Members of AAMFT, be identified as integral providers of mental health services. We make this recommendation because of the broadly recognized findings regarding the importance of the family system in the maintenance of physical and mental health and in the recovery from illness.

For example, studies have documented that marital stress, separation and divorce have a profound impact on health and medical utilization. In addition, it has been documented that hospital admissions are generally highest for separated and divorced individuals. In fact, admission rates for the divorced have been reported to be from 6-10 times greater than the rate for married individuals. Evidence also suggests that divorced individuals have the highest hospital admission rates for most diagnostic categories, the highest rate of alcoholism, suicide attempts and four to five times as great a utilization of outpatient psychiatric services as their married counterparts.

Furthermore, it has been reported that almost 50% of those who seek psychiatric help in times of crises have a serious marital or family problem as an etiological factor. Certainly, this information points to the need for treating the family as a system, rather than treating just the individual, and for the recognition of providers who are specifically and rigorously trained to treat problems from a family systems perspective.

Currently, several factors in the existing system of care limit access to needed mental health services and highly trained mental health providers:

A) Despite AAMFT's success at the state level in recent years, state legislatures remain reluctant to venture into the field of professional regulation. Therefore, the passage of state regulatory laws is far more difficult today than even ten or fifteen years ago. With this patchwork regulatory picture, individuals and families find their choices of provider, and therefore their access to services, limited. Further, consumers who find themselves in need of services may lack protection from unscrupulous or incompetent providers. In short, the lack of regulation limits access to necessary mental health care, particularly in rural and underserved areas where there is already a well-documented shortage of qualified mental health professionals. This concern can be remedied by encouraging states to regulate all mental health professionals, including marriage and family therapists, both to ensure access to care and to ensure consumer protection.

In its recent report on allied health services, the Committee to Study the Role of Allied Health Personnel of the National Institute of Medicine underscored the need for regulation of allied health professionals by recommending that states which identify areas of needed regulation provide statutory certification for individuals in these health fields. In addition, the Institute of Medicine report recommends that Medicare and other third-party payers accept state title certification as a prerequisite for reimbursement eligibility. Such action is crucial in order to remove current barriers to access and to ensure that future health and mental health service needs are met by marriage and family therapists and other qualified health and mental health providers.

B) Public systems -- particularly Medicare and Medicaid -- have not kept pace with developments in mental health care which have occurred in recent years. As a result, access to necessary mental health services, including marriage and family therapy, for those with inadequate private insurance or with no insurance coverage is severely limited. Congress should amend Medicare and Medicaid in two ways: 1) expand the mental health provider base in both systems to include marriage and family therapists, social workers, psychologists, and psychiatric nurses. With psychiatrists, these four practitioner groups round out the five core mental health disciplines recognized under the Public Health Service Act; and 2) supply sufficient funding to ensure a mental health benefit to those who have inadequate private insurance or no private insurance coverage at all. Access to necessary mental health care services, including marriage and family therapy, should not be denied because of inability to pay.

While the Pepper Commission is not charged with defining the specific provisions or benefits of a health/mental health care plan, an appropriate starting point for discussion is the mental health package contained in the Basic Health Benefits for All Workers Act (S. 768/H.R. 1845), introduced by Pepper Commission members Senator Edward Kennedy (D-MA) and Congressman Henry Waxman (D-CA).

2) **The Commission should recommend that federal health policy recognize the vital role of family involvement in health and mental health care and facilitate the provision of training and support services for family caregivers, including marriage and family therapy and the services provided by marriage and family therapists and other mental health professionals**.

Family involvement obviously is critical in long term care for the elderly and disabled, but is also an extremely important factor in the diagnosis and treatment of health and mental health care problems.

Under the traditional medical model, the primary focus of diagnosis and treatment has been on the affected individual. But there is growing evidence to suggest that we must reconceptualize health and mental health care specifically to involve the family in treatment whenever possible. There are a number of reasons why federal policy should recognize and facilitate family involvement whenever possible:

1) the impact of one family members' illness on other family members is often severe;

2) medical utilization of other family members typically increases when a family member is severely or chronically ill;

3) intrafamily dynamics may be a contributing factor in the severity of an illness, including mental and emotional disorders;

4) treating only the affected individual does not address intergenerational issues which may arise when family members are stressed by providing care for their loved one, whether in the home or in partnership with a nursing home, hospital or other institution;

5) involvement of the family throughout the treatment process often increases the effectiveness of both health and mental health treatment and sustains recovery;

6) strong involvement of the family throughout the continuum of care is more cost-effective than individually-oriented treatment.

The idea of family involvement in the diagnosis and treatment of physical illness and mental and emotional disorders is not new. To the best of their ability and within financial constraints, family members care for each other every day, whether for reasons of ill health or mental and emotional disorders. In fact, 80 percent of long term care is provided by family members in the home. What is new is a growing understanding of the need to institutionalize or systematize this care by providing federal recognition of and support for the vital services which family members provide for each other.

To date, such recognition usually takes the form of respite care for family members. Research has shown that respite care is absolutely crucial in preventing "burn out" among caregivers, so that they can continue to provide care to their loved ones. But respite care, alone, is not sufficient. Greater flexibility in federal policy could do a great deal more to develop a partnership with family members to facilitate more appropriate, and in some cases less costly, care for those in need.

For instance, marriage and family therapists in a variety of settings, including nursing homes, hospices, and in clients homes, are training family caregivers across the country in how best to cope with the high stress of daily caregiving. Despite the growing need for family therapy services, however, many elders and their families who seek consultation with marriage and family therapists are denied access to these professionals because current Medicare policy does not recognize them for reimbursement. Medicare policy must be updated to recognize the crucial contributions of marriage and family therapists and other health and mental health care providers if the comprehensive needs of an aging population are to be met.

In addition, Congress should amend the qualifications which determine Medicare coverage for respite care to make them more flexible. The current standards are so rigid that family caregivers often find them to be a barrier to accessing needed respite care services. Other areas in which federal policy could and should facilitate family involvement in the daily care of their loved ones with physical illness and mental and emotional disorders include changes in federal tax policy and amendments to the Social Security system, especially for caregivers who are unable to work outside of the home, due to their caregiving responsibilities.

3) **The President and Congress must work cooperatively with the private sector to improve the delivery of health and mental health care services and to develop a strategy to finance long term care for the elderly and the disabled**.

Federal fiscal constraints and resistance to raising new sources of revenue are likely to continue into the foreseeable future, thus eliminating funding and policy options which might have been available in years past. In addition, an aging population, HIV infection and substance abuse will increasingly place extraordinary stress on existing publicly funded health systems (e.g. Medicare, Medicaid, CHAMPUS.)

Even with increased funding from state and local governments, which is by no means guaranteed, the public sector will be unable to meet the needs of all persons who will be in need of health and mental health care and long term care services in the future. Therefore, a public-private partnership is crucial if we as a nation are to find solutions for funding the provision of health, mental health, and long term care, for the elderly and non-elderly alike.

AAMFT believes that Senator Kennedy's and Congressman Waxman's Basic Health Benefits for All Workers Act (S. 768/H.R. 1845) provides a framework from which to begin the debate for public-private action. Some in the private sector have argued that the costs of mandating minimum health and mental health benefits would be prohibitive. While acknowledging private sector concerns, it is important to recognize that the costs of providing health and mental health care and long term care among the uninsured are currently shifted from some in the private sector who offer no private insurance to government and other sectors of industry. The Pepper Commission must factor the "costs" of the current system -- including the realities of current cost-shifting, overloaded public hospitals, and inadequate public financing of health care -- into the debate that the private sector and consumers already pick up both the costs of providing care and also of not providing care. All Americans "pay" in some way for the shortcomings in the current health care financing system.

SUMMARY

On behalf of the American Association for Marriage and Family Therapy, I would like to summarize the Association's recommendations to the Commission:

1) **Mental health care, including marriage and family therapy, is an integral component of a comprehensive, effective health care delivery system. As such, the provision of mental health services, including marriage and family therapy, must be a part of the Commission's recommendations on both health care system access improvements and long term care. Further, AAMFT recommends that all qualified mental health professionals, including marriage and family therapists, be recognized as integral providers of these services.**

2) **The Commission should recommend that federal health policy recognize the vital role of family involvement in health and mental health care and facilitate the provision of training and support services for family caregivers, including marriage and family therapy and the services provided by marriage and family therapists and other mental health professionals**.

3) **The President and Congress must work cooperatively with the private sector to improve the delivery of health and mental care and to develop a strategy to finance long term care for the elderly and the disabled**.

I appreciate having the opportunity to participate in the Pepper Commission's development of recommendations to improve the delivery of health and mental health care services in our nation and to develop a long term care strategy. I hope that AAMFT's recommendations will prove useful to you and your colleagues on the Commission.

I encourage you to contact Deborah Simmons, AAMFT's Director of Federal Relations, with questions or if you would like additional information.

Again, many thanks for your consideration of AAMFT's recommendations.

Sincerely,

Mark R. Ginsberg, Ph.D.
Executive Director

WHEN TO REFER FOR MARITAL AND FAMILY THERAPY

A GUIDE FOR PROFESSIONALS

from
The American Association for
Marriage and Family Therapy

As a professional, you may be the first to recognize marital and family problems which need attention.

Recognizing a problem is but the first step in finding a solution. Making a successful referral is even more important. That is when you may choose to refer to a qualified marital and family therapist.

This brochure provides you with a guide for making an appropriate referral to a well-trained marital and family therapist.

IDENTIFYING MARITAL AND FAMILY PROBLEMS

Although all individuals, couples and families experience some problems, it is not easy to identify which problems require the assistance of a professional such as a marital and family therapist.

All of us traverse a series of normal and expected developmental stages, each posing challenges and possible pitfalls. For example, as children move from childhood to adolescence, or adults move from productive employment into retirement, the family may need special support to make necessary changes and adjustments.

Many individuals, couples, and families have special needs and face difficult problems. For example, school failure, a rebellious teenager, or alcoholism and/or substance abuse can have an adverse effect. In addition, most individuals, couples, and families also will face unexpected problems and crises, such as a death in the family, a divorce, a sudden illness, or unemployment. These and other such problems often require professional services such as those provided by qualified marital and family therapists.

DISTRESS SIGNALS

Symptoms of marital and family distress arise as individuals, couples, and families experience normal developmental stages, face special needs and problems, or confront unexpected crises. These symptoms are not always obvious, even to the trained observer. Some distress signals to look for are:

- Feelings of marital and family dissatisfaction.
- Frequent references to a child's behavior, school adjustment, or underachievement.
- Sexual problems or concerns.
- Complaints of "unexplainable" fatigue.
- Emotional distress when talking about one's fiancee, spouse, children, parents, or other family member.
- References to feelings of loneliness, isolation, moodiness, depression.
- Unexplained physical injuries to spouse or children.
- Repeated requests for tranquilizers, energizers or sleeping aids.
- Repeated illnesses or non-compliance with treatment regime.
- Excessive abuse of substances such as alcohol and/or drugs.
- Repeated financial difficulties.
- Inability to set or attain goals.
- Drastic weight fluctuations and/or irregular eating patterns.
- Repeated employment difficulties, frequent job changes, difficulty with co-workers.

PROFILE OF A TRAINED AND QUALIFIED MARITAL AND FAMILY THERAPIST

Marital and family therapists are specially trained to help individuals, couples, and families resolve emotional, marital and family problems.

Marital and family therapists help individuals, couples, and families with pre-marital, marital, parenting, step-parenting, divorce, remarriage, and other such issues.

When making a referral for marital and family therapy, you should be confident that the professional to whom you are referring has been appropriately trained.

The AAMFT clinical member requirements have been established to help professionals and the public identify such practitioners. AAMFT clinical members have a minimum of a Masters degree including specific graduate training in marital and family therapy, and also have completed at least two years of supervised clinical practice with couples and families. In addition, clinical members of AAMFT meet applicable state licensure requirements.

AAMFT clinical members are trained in the diagnosis and treatment of mental and nervous disorders and also are knowledgeable in such areas as human growth and development, behavioral patterns, marital and family interaction, sexual dysfunction, parent-child relationships, and the dynamics of family systems. They are trained to use a variety of therapeutic techniques and processes.

AAMFT clinical members observe a strict ethical code and welcome inquiries about their training, experience, theoretical orientation, length of treatment, goals of therapy and fees.

HOW AND WHEN TO MAKE A REFERRAL

If you believe that an individual, couple, or family could benefit from marital and family therapy, refer to a marital and family therapist you know personally or professionally, or AAMFT will be pleased to provide you with the names of AAMFT clinical members in your community.

- **REFER** at the first sign of emotional, marital or family distress. Delay can compound the problem.

- **PROVIDE** your client with the names of several qualified marital and family therapists.

- **SUGGEST** that your client call and request information regarding the practitioner's training, experience and fees.

- **DISCUSS** a marital and family therapist's special areas of expertise with the person(s) you are referring and suggest that the client do so as well.

- **REFER** couples and/or families for therapy together.

- **ASK** the family to use your name as the referring professional when they make their initial call to the marital and family therapist.

- **FOLLOW UP** with both your client and the marital and family therapist.

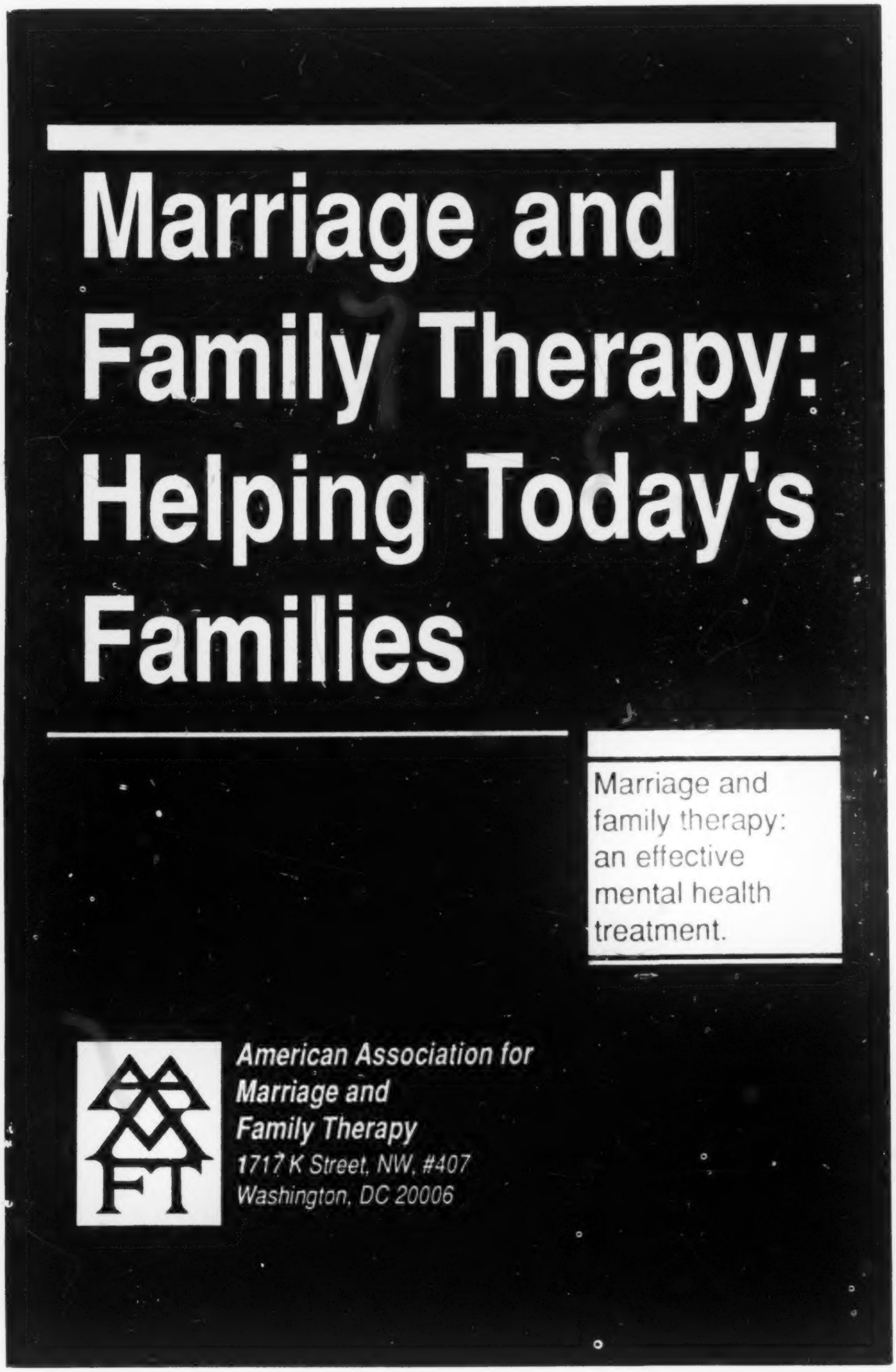
AMERICAN ASSOCIATION FOR MARRIAGE AND FAMILY THERAPY

Since 1942, The American Association for Marriage and Family Therapy (AAMFT) has been involved with the problems, needs and changing patterns of marital and family relationships. The Association leads the way to increasing understanding, research, and education in the field of marital and family therapy, and to ensuring that public needs are met by well trained practitioners. AAMFT believes that therapists with specific education and training in marital and family therapy provide the most effective mental health care to couples and families.

AAMFT is the professional organization representing more than 14,000 qualified marital and family therapists in the United States, Canada, and abroad. The Association sponsors conferences for professional interchange and training; publishes the Journal of Marital and Family Therapy, Family Therapy News, and other professional publications; advocates for public policies of concern to the marital and family therapy community; and, in the public interest, administers a referral service.

For more information, contact:

The American Association for Marriage
and Family Therapy
1717 K Street, NW, Suite 407
Washington, D.C. 20006
202/429-1825



Marriage and Family Therapy: Helping Today's Families

Marriage and family therapy: an effective mental health treatment.

American Association for Marriage and Family Therapy
1717 K Street, NW, #407
Washington, DC 20006

[redacted]

Written by: John Hutchins

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What Is Marriage and Family Therapy?

Marriage and family therapy is the rapidly growing, family-oriented mental health discipline which helps thousands of individuals and families worldwide. Marriage and family therapists help people within the context of their families and the communities in which they live.

The American Association for Marriage and Family Therapy (AAMFT), the professional organization of more than 15,500 marriage and family therapists in the US, Canada, and abroad, has prepared this brochure for health care administrators, legislators, other policy makers, the media and the general public to answer the following questions and provide information about the profession.

- What is marriage and family therapy?
- How does it work?
- In what situations do people turn to marriage and family therapists?
- How effective is marriage and family therapy as a form of treatment and as a method of prevention?
- In what settings do marriage and family therapists work?
- Why has the field of marriage and family therapy grown so rapidly in the last decade?
- What can AAMFT do for you?

What Is Marriage and Family Therapy?

Marriage and family therapists seek to help people within the context of their families, using family systems theories and intervention procedures. As clinicians, they play multiple roles in providing effective health and mental health care for a wide range of problems, from treating patients with psychiatric disorders, to teaching couples how to communicate better. Marriage and family therapists also teach, conduct research, and consult with other professionals.

Marriage and family therapy has become a distinct discipline with graduate and undergraduate programs granting degrees in marriage and family therapy. Historically, however, marriage and family therapists have come from a wide variety of educational backgrounds including psychology, psychiatry, social work, nursing, pastoral counseling, and education. This diversity has enriched the field by bringing different perspectives to the problems of individuals and families, while marriage and family therapists' strong belief in the importance and power of the family system as an instrument of change has brought unity to the discipline.

Although marriage and family therapists use a wide variety of treatment methods and procedures, they share the following views:

- An individual's problems or difficulties need to be understood in the context of the family -- both the nuclear family and the extended family. The second most important context is the community where the family lives.
- In general, the most effective and efficient way to help a person in need is to involve the other members of their family so that the family reinforces any program of change.
- To help an individual change, overcome a problem or learn to cope better, the family may need help to change its patterns.
- The family's patterns may influence the problem, are usually affected by it, and need to be part of the solution.

"Family therapists are distinct as a group largely because of a common assumption: if the individual is to change, the context ... must change. The unit of treatment is no longer the person, even if only a single person is interviewed; it is the set of relationships in which the person is imbedded."[1]

When Do People Turn to Marriage and Family Therapists?

Family therapy is not just for those who are married or who would say they have a family problem. Single or married people, of all ages, and in all types of situations, seek help from marriage and family therapists. Some of the reasons that increasing numbers of people turn to marriage and family therapists are:

- Persistent problems with a child's behavior, school adjustment or performance.
- Sexual concerns.
- Feelings of loneliness, moodiness, depression, failure or anxiety.
- Difficulty in talking with family members, friends or co-workers.
- Alcohol and/or drug abuse.
- Repeated financial difficulties.
- Drastic weight fluctuations or irregular eating patterns.
- Chronic work difficulties, frequent job changes, problems with co-workers.
- Unmanageable anger, hostility or violence.
- Persistent feelings of dissatisfaction with marriage or family life, episodes of infidelity.
- Persistent difficulty coping with stresses arising from life crises: for instance, death, divorce, acute or chronic illness, or unemployment.
- Trouble adapting to life cycle changes such as children moving into adolescence, or adults retiring.
- Desire to improve one's marriage and family life.

How Does Marriage and Family Therapy Work?

Marriage and family therapy usually requires only a limited number of therapy sessions. In a recent survey, AAMFT members reported that 70% of their clients complete their therapy in 25 sessions or less, while many finish in ten sessions or less.[2]

Family therapists focus on changing behavior and communication among people through active interventions. They may assign family members particular tasks or "homework" to accomplish between sessions. In this way, the therapist helps to change patterns of interaction in a family that contribute to their difficulties.

Family therapists typically involve other members of the family in treatment, including parents, children, or grandparents, and might involve significant others in the community such as teachers, welfare workers, clergy, and probation officers. Contrary to most people's expectations however, marriage and family therapists do not work only with whole family units; they frequently treat individuals by themselves, couples, and other family sub-units. Typically, only part of a marriage and family therapist's practice consists of treating entire families.

The Many Roles of Marriage and Family Therapists

Marriage and family therapists work in a wide variety of settings including:

- independent practices and group practices,
- inpatient settings (hospitals),
- outpatient facilities (clinics), public and private agencies .

Sometimes they work in teams with other health care professionals, such as family physicians. Marriage and family therapists are also often involved in other professional activities besides direct treatment. They provide consultation to schools, employee health care assistance programs, health clinics, private and public social service agencies, and businesses. They also are involved in family research and public policy analysis from a family perspective.

In an independent practice setting:

- Paul (35) and Barbara (32) have been married for six years and have a 5 year-old named Mike. Both Paul and Barbara have full-time, well-paying jobs. Mike is well-adjusted and likes school. Paul has been travelling a lot recently for work and the couple's usually infrequent sexual contact has dwindled to almost nothing. Six months ago, Barbara discovered a letter to Paul from a woman who lived in a city he visits frequently on business. It contained sexual undertones. Two weeks ago, the couple had a bitter fight over Paul's desire to bring Mike along on a weekend business trip. Barbara refused to let Mike go and disclosed her knowledge of the letter, saying she was afraid to have Mike accompany him. She threatened to take Mike and leave. Paul said she was having delusions, suggested she find them a therapist, and went out-of-town by himself.

Treatment consisted first of discussing the couple's personal history and the development of their relationship. Based on those discussions, it became clear neither learned from their family of origin how to be intimate . They were also involving their son in their own struggles. Finally, through therapy, both spouses defined a new basis for their marriage and learned the skills and attitudes they needed. As a result, they became more trusting of one another, risked greater intimacy, and functioned much better as a married couple.

In Outpatient Settings and Independent Practice

The primary setting for the practice of marriage and family therapy is outpatient treatment of individuals and families. Marriage and family therapists treat a wide range of clients, including children unable to perform in school, couples in troubled marriages, people with drug and alcohol problems, and other individuals with mental or nervous disorders.

Marriage and family therapy has been successful in treating, among other problems, alcoholism, anorexia and other eating disorders, psychosomatic asthma, overly aggressive children, juvenile delinquency, and other problems.[3] When com-pared to other treatments, marriage and family therapy has consistently been more effective in improving family interaction patterns and individual patient behavior, especially for problems that involve marital and/or family conflict.[4]

In Inpatient Settings

Marriage and family therapists provide valuable patient care in hospitals and mental health institutions, as well as aid in the transition of hospitalized patients to home-based care provided by their families.

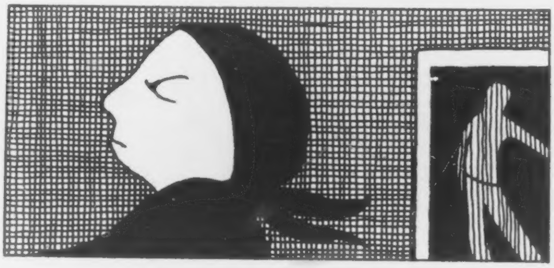
In the inpatient treatment of mental and emotional illnesses, such as schizophrenia and chronic affective disorders, family therapy procedures have produced improvement and lowered the risk of subsequent hospitalization.[5] Family therapy aftercare for schizophrenics released following their first or second admission has reduced their six-month rehospitalization rate from 30 percent to zero in some studies.[6]

Family therapy also provides alternatives to fulltime hospitalization by substituting a limited amount of home care which actively involves the family in treatment. The results are as good as, if not better than, traditional psychiatric hospitalization in both short-term and long-term follow-up. Costs are lowered as well. In a 1981 study of psychotic patients, researchers found that psychotic relapses were "nine times more likely to occur for patients receiving individual treatment than for those receiving a practical, problem oriented, negotiation-centered family therapy."[7]

In a hospital setting:

- Jennifer is a 14 year-old suffering from anorexia nervosa. She has lost 20 pounds in the last four months and her parents are exasperated. They have tried everything — threats, enticements, understanding, punishment — and nothing has worked. One day, Jennifer faints at school and her parents must hospitalize her. The physician refers them to a family therapist. Over the course of several sessions in the hospital, the family therapist helps the family to learn to interact differently around Jennifer's refusal to eat by encouraging them to change a damaging family pattern, in this case by empowering the daughter to take more control over other areas of her life, and supporting the parents who are facing a terrifying, life-threatening situation. The therapist gives the family homework assignments to support the family as a whole, but also to foster Jennifer's independence. For example, upon her return home Jennifer is given the responsibility for planning a family weekend vacation. Eventually, tensions are reduced. Jennifer's need to rebel against her parents by not eating becomes no longer necessary.

Based on these findings and other research, there is strong reason to believe that family-centered treatment is cost effective for other types of chronic illness. The current trends of short-term hospitalization, with recuperation at home, and home treatment of the long-term chronically ill, have made marriage and family therapy an important component of comprehensive health care offerings among innovative institutions.



In Managed Care Programs

Many health maintenance organizations, employee assistance programs and other corporate managed health care systems are finding that marriage and family therapy provides cost-effective treatment. Marriage and family therapists bring a holistic perspective to health care; they are concerned with the overall, long term well-being of individuals and their families.

For instance, research shows that marriage and family therapy is particularly successful in the treatment of alcoholism. Marriage and family therapy allows for a broader, systemic view of the presented problem and provides new opportunities to find solutions. Studies show that the use of medical services can decrease when appropriate mental health services are provided, including marriage and family therapy.[8]

In some cases, marriage and family therapy has demonstrated more long term effectiveness than other outpatient therapies.[9] One recent review of family therapy research examined long term effects and found that, in follow-up periods ranging from six weeks to three years, 58% of alternative therapy patients required further treatment, as compared to only 36% of those in family therapy.[10] When other measures of recidivism are examined, such as hospitalization, family therapy also shows a higher success rate than alternative treatments.[11]

Family Therapists as Systems Consultants

More and more, family therapists work as systems consultants, providing case consultation, program consultation and in-service staff training to a variety of human service professionals, administrators, and corporate managers in both public and private settings. These settings include health and mental health institutions, social services, courts, schools, the military, corporations, and community groups.

The goals of systems consultation may include: increasing awareness of how family factors influence work productivity, educational achievement, health; assisting managers and staff to make their institution more sensitive to organizational and family factors; knowing when and how to refer individuals and their families for further specialized assistance; helping the institution make its component parts work together effectively and efficiently; and assisting the institution in developing and maintaining relationships within the broader community.

Family Therapists as Researchers

Family therapy had its beginnings in the clinical study of various aspects of the processes of families with a schizophrenic member.[12] Today, marriage and family therapists continue to conduct important research that is advancing our understanding of how families work and leading to more effective treatment of mental and emotional problems. Research is conducted in nearly every major college and university and is also supported by the federal government and private foundations.

Marriage and family therapists are interested in the enrichment of the lives of people and their families, as well as in their problems. Family therapy research continues on how normal, healthy families operate, including studies on family communication patterns, problem-solving styles, issues of autonomy and interdependence among family members, sexual functioning, and coping with life cycle events like birth, marriage and death.

The Field of Marriage and Family Therapy Is Growing

Marriage and family therapy's prominence as a profession has increased dramatically in the past 25 years, particularly in the last decade. In 1960, the American Association for Marriage and Family Therapy (AAMFT) had only 237 members. Today there are more than 15,500 members throughout the United States and Canada; 8,500 of these members have joined since 1977.

AAMFT's Commission on Accreditation for Marriage and Family Therapy Education is recognized by the U.S. Department of Education as the sole accrediting authority for marriage and family therapy education. The number of accredited marriage and family therapy graduate training programs grows every year. This growth is a result, in part, of renewed public awareness of the value of family life and concern about the increased stresses on families in a rapidly changing world.

All AAMFT members are subject to the *AAMFT Code of Ethical Principles for Marriage and Family Therapists* which clearly delineates accepted professional standards relating to responsibility to clients; confidentiality; professional competence and integrity; responsibility to students, employees, and supervisees; responsibility to the profession; financial arrangements; and advertising. The association has an active disciplinary committee that holds members to high practice standards. The profession also draws strength from a growing conviction that marriage and family therapy leads to more cost-effective treatment.

Marriage and family therapy is recognized increasingly as a valuable, and distinct, mental health profession. Eighteen states now require licensing or certification of marriage and family therapists. Many more state legislatures are working on similar laws.

The AAMFT Research and Education Foundation promotes research in the field of marriage and family therapy and activities designed to promote general family well-being. The Family Impact Seminar, the policy unit of the Foundation, conducts policy-oriented research and sponsors non-partisan informational seminars for federal and state policy staff on topics such as teenage pregnancy, child care, and long-term care, seeking to provide them with a family-centered perspective in policymaking.

The success of marriage and family therapy is evident by thenumber of consumers who are increasingly turning to marriage and family therapy for treatment. A growing number of third-party payors are providing coverage for marriage and family therapy. For example, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the health insurance program for dependents of U.S. armed services personnel, has reimbursed marriage and family therapists for their treatment services since 1966.

Third-party payor reimbursement from health insurance companies, employee assistance programs (EAPs), and health maintenance organizations (HMOs) has risen dramatically in recent years. While this trend is encouraging, marriage and family therapists are working to gain further recognition from third party payors.

What Can AAMFT Do For You?

The American Association for Marriage and Family Therapy and its members offer a number of services to legislators, policymakers, health care administrators, the media, and the public, including:

- Lists of qualified marriage and family therapists: AAMFT provides referral lists by mail or phone for every state, province, and community in North America.

- Expert consultation on public policy regarding health and mental health issues, especially as they relate to the ability of families to afford adequate health care.

- Expert testimony as witnesses on topics such as alcohol and substance abuse, AIDS, and domestic violence from a family perspective.

- Model legislation for state licensure of marriage and family therapists.

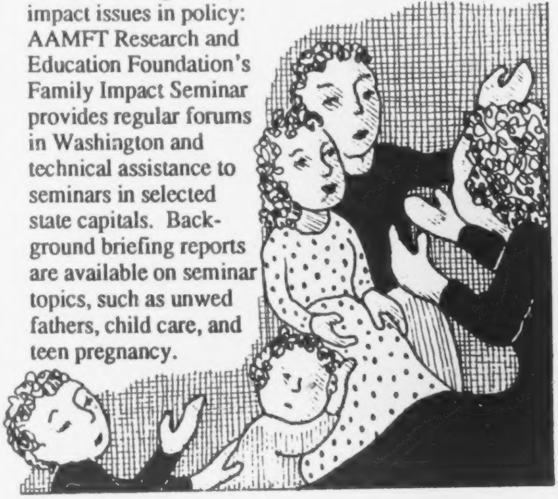
- Advocacy: AAMFT represents the professional interests of marriage and family therapists in dealing with local, state and national governments, health care organizations, and insurance companies in the United States and Canada. Joining together with like-minded organizations, through such groups as the Coalition of Family Organizations (COFO), AAMFT advocates for family-centered policy and mental health issues.

- Research on family problems and effective treatments: AAMFT is able to draw on the expertise of its members to refer you to the most up-to-date treatment methods and efficacy studies available.

- Seminars for policy staff addressing family impact issues in policy: AAMFT Research and Education Foundation's Family Impact Seminar provides regular forums in Washington and technical assistance to seminars in selected state capitals. Background briefing reports are available on seminar topics, such as unwed fathers, child care, and teen pregnancy.

- Publications related to family policy, including *A Strategy for Strengthening Families: Using Family Criteria in Policymaking and Program Evaluation* and *Questions and Answers About Family-Centered Policymaking*.

- Publications: *The Journal of Marital and Family Therapy*, published by AAMFT, is a comprehensive resource for the latest trends and research in the field. The *Family Therapy News*, a bimonthly newspaper, and a variety of informational brochures for the public are also available from AAMFT.



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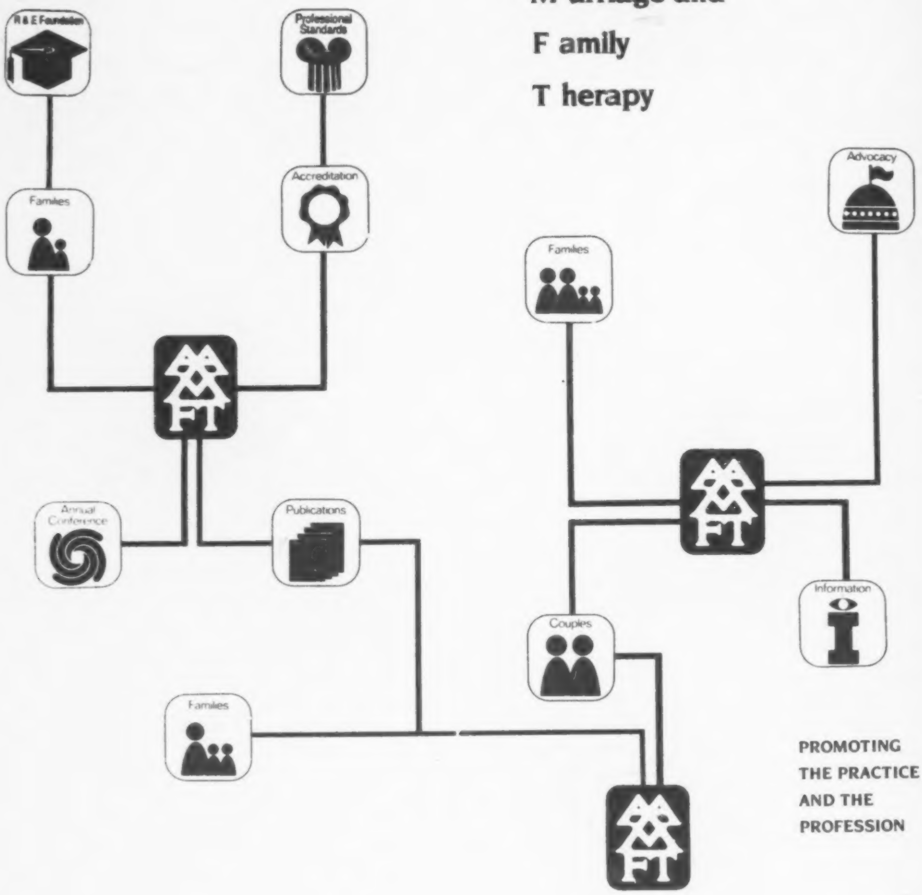
American
Association for
Marriage and
Family
Therapy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PROMOTING
THE PRACTICE
AND THE
PROFESSION

AAMFT serves its members, the profession, and the public through programs in these areas:

PROFESSIONAL STANDARDS

AAMFT members serve the increasing public demand for marriage and family therapy. Membership may be held at the Clinical, Associate, or Student level. Clinical Members have completed specific graduate training in marriage and family therapy, as well as extensive supervised clinical experience with couples and families.

All members subscribe to the *AAMFT Code of Ethical Principles for Marriage and Family Therapists*. The Association offers leadership in ethical education and rigorously enforces the Ethical Code.

AAMFT Approved Supervisors have received recognition, through the AAMFT Commission on Supervision, for meeting the highest standards of clinical education and practice, advanced clinical skills, and special training in the supervision of marriage and family therapists.

ACCREDITATION

AAMFT is at the forefront of defining and promoting criteria for the education and clinical training of marriage and family therapists. The AAMFT Commission on Accreditation for Marriage and Family Therapy Education is recognized by the United States Department of Education as the sole national accrediting agency for graduate educational programs in marriage and family therapy. The Commission accredits graduate-degree and post-graduate training institutes throughout the United States and Canada.

PUBLICATIONS

AAMFT has a growing library of publications and videotapes designed to promote the practice and the profession of marriage and family therapy. They include the *Journal of Marital and Family Therapy*, a quarterly journal which advances the professional understanding of marriage and family therapy behavior; *Family Therapy News*, a bi-monthly newspaper with news, features, and professional opinion; a register of Clinical Members and Approved Supervisors which is an invaluable referral source used by members, EAPs, HMOs, PPOs, and others; and, brochures such as *When to Refer for Marital and Family Therapy* and *A Consumer's Guide to Marriage and Family Therapy* used to help educate professionals and consumers about when and how to locate a marriage and family therapist. Annually, AAMFT publishes new materials that are at the forefront of the field.

The AAMFT Master Series™ are videotapes which demonstrate the application of theory and technique to challenging clinical populations; while the Family Therapy Training tapes are tapes of AAMFT conference plenary sessions on various topics which serve as valuable teaching tools.

ANNUAL CONFERENCE

The AAMFT Annual Conference brings together leading marriage and family therapists from around the world to provide over 250 workshops and seminars emphasizing the most recent developments in theory, practice, and research. Honors are given to those who make significant contributions to the field through the presentation of awards for research and special accomplishments. The conference, with more than 4,000 attendees, features live therapy sessions by international experts, video presentations, and numerous networking opportunities.

ADVOCACY

AAMFT represents member concerns on legislative and policy matters to the United States Congress, state and provincial legislatures, and other government agencies. AAMFT staff maintain contact with other national professional associations and with professionals in related fields. The staff also participate in several coalitions of mental health and family related organizations regarding advocacy for public policy at both the state and federal levels. The AAMFT Political Action Committee (AAMFT PAC) promotes the goals and objectives of the Association through the advocacy process by supporting candidates for federal office who can help further AAMFT's goals.

RESEARCH & EDUCATION FOUNDATION

The AAMFT Research and Education Foundation, a tax-exempt arm of the Association, promotes research and education in the field of marriage and family therapy through the awarding of research grants, awards, fellowships, and scholarships. The Family Impact Seminar, the policy unit of the Foundation, conducts policy research and sponsors non-partisan informational seminars for federal and state policymakers on family-related issues.

INFORMATION

AAMFT provides many kinds of information to a diverse public.

- AAMFT provides information regarding the inclusion of marriage and family therapy and marriage and family therapists in the evolving systems of health care delivery. Material outlining treatment effectiveness and service delivery models is available to HMOs, PPOs, EAPs, and other health care organizations.
- The Family Impact Seminar serves as a source of nonpartisan information on family issues for federal and state/provincial policy staff, and the general public.
- AAMFT also serves as a clearinghouse for public information for radio, television, the print media, and other journalists and researchers.

Along with the professional affiliation of membership in AAMFT, member benefits include availability of health, life, disability, professional liability, and malpractice insurance; listing in a register of AAMFT Clinical Members and Approved Supervisors—a referral source; discounts on Annual Conference registration and publications; and access to the AAMFT Legal Consultation Plan.

AAMFT and its Foundation strive to offer a perspective on marriage and family concerns, to provide information regarding the practice and profession of marriage and family therapy, and to promote a family perpective in mental health, health and social services, and public policy.

AAMFT,
the bridge to
the future.

The American Association for
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For nearly 50 years, the American Association for Marriage and Family Therapy (AAMFT) has been involved with the problems, needs and changing patterns of marriage and family relationships. The Association leads the way to increasing understanding, research, and education in the field of marriage and family therapy, and to ensuring that public needs are met by well trained practitioners. AAMFT believes that therapists with specific education and training in marriage and family therapy provide the most effective mental health services to couples and families.

The more than 16,000 members of AAMFT have met rigorous educational and clinical training requirements — now recognized as the standard in the field. Members of the Association are professionals who work with individuals, couples, and families.

AAMFT is the professional organization representing marriage and family therapists in the United States and Canada. The Association's divisions are active at the state and provincial level, advocating for marriage and family therapy professional issues, sponsoring professional services, and serving as a forum for professional interchange.

June/1989

National Federation of Societies for Clinical Social Work, Inc.

February 1, 1990

The Pepper Commission
U.S. Bipartisan Commission on
Comprehensive Health Care
140 Cannon House Office Building
Washington, D.C. 20515

Enclosed is a statement from the National Federation of Societies for Clinical Social Work concerning the problems of access to mental health care for all Americans. We appreciate the opportunity to comment on issues of importance to the mental health community for review and consideration by the Members of the Pepper Commission.

Sincerely,

John C. Dill

Cidette Perrin

Enclosure

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National Federation of Societies for Clinical Social Work, Inc.

Summary

The National Federation of Societies for Clinical Social Work (NFSCSW) is pleased to present its views before the U.S. Bipartisan Commission on Comprehensive Health Care ("The Pepper Commission") regarding access to affordable mental health care for all Americans.

Clinical social workers are the single largest body of mental health professionals in the United States. They are involved in virtually every component of the nation's health care delivery system, providing services to individuals, groups and families through private practice, group practice settings, health maintenance organizations, hospitals, agencies, clinics and employee assistance programs. They treat a spectrum of problems, ranging from emotional disorders such as depression and anxiety to severe mental illness.

Today, an estimated 37 million Americans are uninsured, and millions more lack adequate coverage. Moreover, the access problem is far worse for persons in need of mental health treatment than it is for those seeking treatment for physical illness.

The current debate on how to solve the problem of universal access to affordable health and mental health care has focused on a number of proposals, most of which advocate a combination of private and public initiatives. One such proposal is the Basic Health Benefits for All Americans Act (S.768/ H.R.1865), sponsored by Senator Edward Kennedy (D-MA) and Congressman Henry Waxman (D-CA). The private coverage portion of the bill is an employment-based system that would require employers to extend a basic level of health and mental health coverage to employees and their families. The public program is a Federal-State program that would provide coverage to uninsured Americans not covered by employment-based insurance or by other public insurance. NFSCSW endorses the Kennedy/Waxman legislation

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and strongly supports the concept of mandates (either State or Federal), but we believe the proposed minimum mental health benefit is, in the long run, insufficient to meet the needs of Americans requiring treatment for mental disorders. For the reasons set forth below, NFSCSW urges the Pepper Commission to include in its final report to Congress a recommendation which would assure all Americans an adequate level of mental health coverage and the freedom to choose from a range of qualified mental health providers, including clinical social workers.

The Need for Mental Health Coverage

The prevalence of mental illness in the United States is widespread. Approximately 29.4 million adult Americans (or 18.7 percent of the population) suffer from one or more mental disorders in any six month period. And each year, more than 10 million Americans are affected by depression-- one of the most common mental health disorders. Despite such statistics, current private and public insurance coverage discriminates against mental illness by providing less comprehensive coverage than for physical ailments. Higher beneficiary copayments and deductibles are generally required for mental health coverage, and maximum benefits are lower.

The Medicare program provides an example of the differential coverage of mental illness. Until recently, Medicare imposed an annual cap of $1,100 on outpatient mental health services. The cap was removed by enactment of H.R.3299 (the Omnibus Reconciliation Act), but Medicare continues to require a significantly higher beneficiary copayment for treatment of mental disorders than it does for treatment of physical illness.

As society has become increasingly aware of the interrelatedness between physical and mental health, an impressive body of evidence has accumulated which demonstrates that mental health treatment can offset the use and cost of unnecessary medical care. More and more studies have shown that the inclusion of mental health care in health care delivery systems can improve the quality and appropriateness of care, while also lowering overall costs.

Recently, after reviewing the research on the correlation between mental health treatment and a subsequent reduction in medical care utilization, the highly respected Washington Business Group on Health (WBGH), in conjunction with the Office of Disease Prevention and Health Promotion of the Public Health Service (PHS), launched a national campaign to examine the problems of mental health in the workplace. One of the concerns the WBGH/PHS project intends to address is the absence of a model mental health benefit.

The WBGH/PHS initiative and the findings from the research literature on the cost offset effects of providing mental health treatment underscore the importance of including in any comprehensive universal health plan a mandated minimum level of mental health coverage. Specifically, NFSCSW suggests that the

Commission use as a model outpatient mental health benefit the recommendation set forth last year by The Health Policy Agenda for the American People, a coalition of 172 organizations committed to improving the availability and quality of health care for all Americans. The Health Policy Agenda developed a basic health benefits package as a guide for private and public benefit plans. Stressing the importance of providing coverage for mental as well as physical illness, the coalition included in its basic benefits package a minimum mental health benefit of up to 50 outpatient visits per year.

The Need for Consumer Freedom of Choice

Universally mandated mental health coverage alone does not ensure that a consumer will have access to needed care and treatment. The consumer must also be guaranteed the freedom to select from a range of qualified providers. There are several important reasons why any comprehensive insurance program covering mental health services should encourage freedom of choice for the consumer. First, the problem of insufficient access to care is often alleviated, particularly among underserved populations. Recent studies indicate that in many rural areas of the country, clinical social workers are often the only licensed mental health professionals available to provide treatment. Second, freedom of choice promotes greater competition among providers which, in turn, can enhance cost-containment. Clinical social workers typically offer their services at lower cost than other providers. And finally, freedom of choice builds upon existing Federal policy. All of the major government health insurance programs -- Medicare, CHAMPUS and the Federal Employees Health Benefits Program (FEHBP) -- currently pay for the services of qualified clinical social workers.

Freedom of choice can be a critical element in the patient's acknowledgment that he or she needs mental health treatment, in the patient's actual resort to treatment, and in the relationship of trust and confidence in the mental health provider necessary to make that treatment successful.

Conclusion

NFSCSW welcomes the opportunity to present its views before the Commission. We applaud the Commission's efforts to address the problems of access in our present health care delivery system. As you finalize your report to Congress, we hope that you will remember the many Americans who are afflicted with mental disorders and make recommendations which will insure adequate coverage and access to services.

NFSCSW

Leading the Foodservice/Hospitality Industry

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NATIONAL
RESTAURANT
ASSOCIATION

STATEMENT OF
THE NATIONAL RESTAURANT ASSOCIATION

BEFORE THE PEPPER COMMISSION

OCTOBER 24, 1989

National Restaurant Association
Comments Presented to the Pepper Commission
November 1989

The National Restaurant Association appreciates this opportunity to present its views on one of the most serious problems our country faces: the fact that millions of Americans lack access to adequate health care.

This issue is among of the Association's most important priorities. We are working with members of the Commission and other policy-makers to develop a series of incentive-based measures that will not only improve access to health care in this country, but will also reduce health care costs, distribute financial responsibility equitably between the private and public sectors, and thereby make it possible for all employers who wish to provide health insurance for their employees to do so.

America's uninsured generally fall into three groups -- the working uninsured, the unemployed uninsured, and the uninsurable. Since the National Restaurant Association represents employers, we will focus our comments on the problems of workers who lack health insurance. Specifically, we will address the main problem confronting restaurateurs who provide or want to provide health insurance to employees -- COST.

National Restaurant Association
Comments Presented to the Pepper Commission
November 1989

The foodservice industry

The National Restaurant Association is the leading trade association for the foodservice industry, the nation's largest retail employer. Foodservice now employs eight million workers; by 2000, industry employment is projected to exceed eleven million.

Although large in the aggregate, the industry consists mostly of small independent entities -- 626,000 units in the United States. Seven out of ten eating and drinking establishments have annual sales of less than $500,000. Most are single-unit, independently-owned operations. About one-half of all units are either sole proprietorships or partnerships. The average net income before taxes for a full menu tableservice restaurant is 5%.

The foodservice industry is unique not only because it is so labor-intensive but because of the nature of its workforce. Foodservice employs large numbers of young, inexperienced and part-time workers, many of whom would otherwise be without jobs. Foodservice operations employ more teenagers than any other industry, and have the shortest average workweek (approximately 26 hours) of any industry.

National Restaurant Association
Comments Presented to the Pepper Commission
November 1989

The industry's sheer size and unique characteristics have led the National Restaurant Association to take a leading role in highlighting the employer's perspective in the health insurance debate.

Foodservice and health insurance

In 1988, the National Restaurant Association Board of Directors established a health benefits task force of board members, state restaurant association executives and other interested parties, and charged the group with gathering data on the state of health insurance benefits in our industry.

According to our research, our members who do not provide health insurance for their employees say -- across the board -- the number one reason they do not do so is the high cost of premiums (see Chart 1). The single biggest factor that would encourage them to provide health insurance, they say, is the lowering of insurance rates (see Chart 2). High costs appear to be a factor in employee decisions not to participate in employer-sponsored programs, as well. The factors foodservice employees listed most frequently as reasons for not participating in employer health programs are (1) they are covered elsewhere or (2) costs are just too high (see Chart 3).

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Based on extensive review of our own, and other, research, as well as the enormous amount of anecdotal information we have compiled from foodservice operators across the country, we feel comfortable in saying that many foodservice operators already provide health insurance for their employees -- and that most of those who don't would like to.

Association survey results show that foodservice operators are very much in line with other industries in providing health insurance to workers. Association research shows that:

1. Almost half of small foodservice companies with annual sales under $500,000 provide health insurance for their employees.

2. Seventy-two percent of restaurant companies with sales of $1 to $5 million a year provide health insurance coverage for both salaried and hourly employees.

3. Ninety-six percent of restaurant companies with yearly sales of $10 million or more provide coverage for salaried and hourly workers.

These statistics illustrate an important point: As small firms grow and become more profitable, they add to their compensation plan. Like other employers, restaurateurs know that in order to attract and keep a loyal and stable workforce, they must offer good benefits. Health insurance is generally one of the first benefits they offer.

A study by the Department of Labor's Bureau of Labor Statistics shows that by the time a company has 100 employees, it will have added health care coverage in almost all cases. Because of this well-documented fact, which is echoed by our own findings in the foodservice industry, we recommend that the Commission direct its attention to removing some of the barriers that discourage employers from providing health insurance.

Why employers often cannot provide insurance

For reasons often completely beyond employers' control, even businesses that provide health benefits for employees often find it extremely difficult to maintain coverage.

A chief reason is the rate of medical cost inflation, now running about twice the general inflation rate. Each year, a greater part of our national wealth is devoted to health care. In 1989, the U.S. will commit more than $600 billion to health care, or nearly 12% of the Gross National Product.

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As the Commission knows, health care costs are being driven up for a multitude of reasons. These include the wider availability of more sophisticated, expensive medical technology; an aging U.S. population that is seeking medical help more often; and critical public health challenges, such as drug addiction and AIDS, that are straining the capacity of our current medical system.

The threat of malpractice lawsuits plays a dramatic role as well. High malpractice insurance premiums and the growing tendency of physicians to order expensive medical tests for patients in order to shield themselves from lawsuits certainly escalate costs. Some estimate the threat of malpractice lawsuits accounts for up to 25% of our nation's health care costs.

State governments have done their part to increase costs by requiring employers to offer an expensive assortment of additional benefits beyond basic medical and hospitalization coverage. It is not unusual, for example, for states to require employers with health plans to cover the services of acupuncturists, chiropractors, naturopaths and dieticians.

And finally, the federal government has also contributed to the problem of high medical costs. Through such laws as COBRA continuation coverage and the recently-repealed Section 89, the federal government has tried to widen health care coverage in the U.S. At the same time, however, these laws greatly escalate the costs of providing health insurance.

Some examples

Following is a snapshot of some of the "real life" problems foodservice operators face in the area of health insurance:

- The Oklahoma Restaurant Association provided group medical insurance to its members for over 20 years. Through ORA's program, foodservice operators could buy insurance for themselves, their families and their employees.

  On Jan. 1, 1989, the American Fidelity Assurance Company cancelled ORA's master plan, leaving 350 foodservice companies without insurance. The cancellation followed a 12-month period during which premiums rose every six months, with the size of the increases ranging from 32% to 143% in December, 1987, and from 60% to 82% in August, 1988, depending upon the persons age and where they lived. After the policy was cancelled, people with a history of chronic illness or with terminal conditions were unable to find coverage anywhere at any price.

- The Missouri Restaurant Association had a similar experience with its longstanding (25-year) group health plan with the same American Fidelity Assurance Company of Oklahoma City.

  Citing increasing losses and declining participation, the company summarily cancelled MRA's entire program effective Jan. 1, 1988. The insurance company gave MRA just 30 days' notice of the cancellation, the minimum required by state law. Cancellation left many members, some with existing health problems, without any health coverage.

- The Melrose Diner in Philadelphia, PA, has for years covered 80% of the premium for individual coverage for its full-time employees, as well as for the dependents of employees who are heads-of-households.

Between 1980 and 1984, Blue Cross/Blue Shield family coverage premiums under the restaurant's plan shot up from $160 a month to $315. In order to continue covering its 80 employees and their families that year, Melrose Diner had to ask all employees to apply for non-group coverage under Blue Cross/Blue Shield. Effective January 1, 1984, the company could no longer provide dependent coverage for new employees. Taking on an extra layer of paperwork, the restaurant continued to provide health insurance through 1984 by writing 80 different checks each month to Blue Cross/Blue Shield to cover each individual's premium payment.

Melrose Diner, a business that has gone to great lengths to ensure good health insurance benefits for its employees, has since obtained coverage through the Pennsylvania Restaurant Association.

- Mr. David Gilbert, Sr., who operates The Rice Planters and Planter's Back Porch in the Grand Strand area of Myrtle Beach, SC, and his employees have been the victims of a well-intentioned federal law that requires employers to allow former employees and their dependents to buy into the employer's group health plan.

  A little-noticed provision of the Consolidated Budget Reconciliation Act of 1985 that has never been subject to the open committee process, the so-called "COBRA requirements" require employers to extend health insurance coverage benefits for certain ex-employees.

  Since 1973, Mr. Gilbert has provided hospitalization and major medical and life insurance to his employees. Until two months ago, Gilbert paid the full premium for individual coverage for his 35 full-time employees.

However, because one former employee, an individual with cancer, took advantage of COBRA continuation coverage, Gilbert's individual premiums increased 230%. Family premiums increased 220% -- all in a 13-month period. Gilbert now pays for only 75% of his employees' premiums.

Alternatives exist

If the Commission wants to help expand health insurance coverage for workers, we recommend the following incentive-based changes:

1. **Eliminate state mandates.** There are currently over 690 state mandates that drive up the cost of health insurance. By removing these state mandates and allowing employers to offer a less expensive, more basic health insurance package, businesses could provide employees with at least some type of coverage at an earlier point in the business's growth cycle.

2. **Give all businesses a 100% tax deduction for the purchase of health insurance.** Only since the *Tax Reform Act of 1986* have the self-employed been able to deduct even 25% of their personal health care premiums.

According to the Employee Benefits Research Institute, 22.4% of the self-employed do not have health insurance, making up a significant portion of the uninsured. Why shouldn't the owner of the corner deli be able to deduct his health insurance costs when General Motors can deduct the health insurance costs for its chairman?

3. **Provide a refundable tax credit for employers who provide health insurance but whose profits are not big enough to make a tax *deduction* an advantage.** New businesses, especially, may not see a profit for several years. A tax deduction does not help or encourage these start-up businesses to provide health insurance for workers. But a tax credit will provide some incentive.

4. **Examine COBRA continuation benefits.** Hearings have never been held on this issue. Making health insurance more expensive for those employers who are already making their best effort to offer health benefits is leading to less health care coverage, not more.

5. **Develop both short- and long-term solutions to address the problem of** rapidly-increasing health care costs. Doctors, hospitals, other health care providers, consumers, and the business community all deserve a role in this debate. We ask the Commission to examine changes in medical procedures as well as malpractice tort reform as ways to help drive down the cost of health care.

6. **Risk pools for the uninsurable could help bridge the gap for those unable** to find insurance elsewhere. We recommend careful study of those state risk pools already operating, calling in testimony at future congressional hearings from risk pool experts.

   We feel strongly, however, that risk pools should be financed through general revenues. Using a tax on employers to finance risk pools would improperly shift the burden to just one segment of society.

7. **Scrutinize the underwriting practices of insurers.** The National Restaurant Association questions the role of the insurance industry in accepting employers' insurance premiums for years and years and then hiking premiums dramatically or cancelling insurance completely when workers file claims.

CONCLUSION

Mr. Chairman and members of the Commission, we hope we have demonstrated that restaurant operators truly want to provide health insurance for their workers. For employers and employees alike, the biggest deterrent to health care coverage is cost. We urge the Commission to recommend incentive-based solutions to the Congress that will allow restaurant operators and other small businesses to continue to provide health care coverage for their employees and remove the barriers that prevent so many from doing so.

CHART #1

Reasons for Not Providing Health Insurance by Sales Volume

(Based on Those Providing Neither Hourly Nor Salaried Employees with Health Insurance)

	PERCENT RESPONDING AFFIRMATIVELY		
	Under $500,000	$500,000 $999,999	$1 Million $4.9 Million
Premiums are too high	73%	83%	92%
Employees covered under spouse or parents' policy	58	55	77
Company is not profitable enough	64	52	62
Employee turnover too high	54	52	46
Administrative expenses are too high	41	52	62
Employees are not interested	24	24	46
Cannot qualify for group policy	22	10	15
Never thought about it	7	10	15
Some other reason	20	21	31

Source: National Restaurant Association Health Benefits Survey

November 1989

CHART #2

Reasons to Consider Providing Health Insurance by Sales Volume

(Based on Those Who Said They Would Consider Providing it in the Future)

	PERCENT RESPONDING AFFIRMATIVELY		
	Under $500,000	$500,000 $999,999	$1 Million $4.9 Million
Insurance rates were lower	96%	95%	91%
Business became more profitable	85	80	91
Minimum coverage rates were dropped	81	80	83
Insurance rates and coverages were more stable	73	80	91
Number of employees increased	73	60	46
It became more difficult to find good employees	58	65	54
Could qualify as a group	58	60	64
Employees requested it	62	45	27

Source: National Restaurant Association Health Benefits Survey

November 1989

CHART #3

Percent of Eligible Employees Participating in Plan

	Under $500,000	$500,000 $999,999	$1 million $4.9 million	$5 million $9.9 million	$10 million and over
Hourly Employees					
Mean	46%	44%	49%	*	63%
Median	35	28	50	*	65
Salaried Employees					
Mean	85%	91%	88%	86%	94%
Median	100	100	100	100	97

Primary reasons given by employees for not participating health insurance.

1. Covered by another/parent/spouse plan
2. Too expensive/costly/can't afford

* Fewer than 20 respondents in median base.

Source: National Restaurant Association Health Benefits Survey

November 1989

COUNTY OF LOS ANGELES • DEPARTMENT OF HEALTH SERVICES
313 NORTH FIGUEROA STREET • LOS ANGELES, CALIFORNIA 90012 • (213) 974- 8101

October 19, 1989

John D. Rockefeller IV, Chairman
The Pepper Commission
140 Cannon House Office Building
Washington, D. C. 20515

Dear Mr Rockefeller:

Enclosed is testimony offered by the Los Angeles County Department of Health Services for the October 24, 1989, hearing of the Pepper Commission on the subject of access to health care to be held in Washington, D. C., on October 24, 1989.

Counties have a unique perspective on the subject of access to health care because they are currently the largest single health care provider for the more than 35 million Americans who do not have any other private or public health coverage. County health care systems are large systems which, though now underfunded and overstressed, are already in place. We believe that national solutions to the problems of insufficient access should begin by expanding and improving these systems.

Thank you for the opportunity to present this perspective in a national forum.

Very truly yours,

Robert C. Gates
Director of Health Services

RCG
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Enclosure

COUNTY OF LOS ANGELES
DEPARTMENT OF HEALTH SERVICES

THE ISSUE OF ACCESS TO HEALTH CARE FROM THE PERSPECTIVE OF COUNTY HEALTH CARE PROVIDERS

The following is offered as testimony by the Los Angeles County Department of Health Services at the October 24, 1989 hearing of the Pepper Commission held in Washington, D.C.

ACCESS DEFINED

We define health care access as the ability of individuals to receive timely medical care as needed. Health care access has become a priority issue nationally because of the more than 35 million Americans who, because they have inadequate health insurance, no health insurance, or lack the money to pay directly for their health care, have either no access or diminished access to health care.

We cannot speak to the access issue without addressing counties as health care providers because the local public sector health care safety net provides the only access to health care available to many of the millions of uninsured. Any measures adopted to address the national access problem will have either to replace or to extend and use the existing local public sector health care systems. We hold the latter alternative to be more economical and less disruptive.

SPECIFIC ACCESS PROBLEMS

Lack of medical coverage is the most common and most obvious barrier to access. There are other more subtle barriers, however.

Even if a facility accepts a patient, inadequate staff or examination rooms in that facility, or inadequacy or obsolescence of equipment, are effective barriers to full access to care. Lack of transportation to and between clinics diminishes a patient's access to facilities that would accept him if he appeared. Fear based on immigration status, and language and socio-cultural barriers also serve to diminish access. Finally, service fees, even nominal ones, may deter the indigent from seeking care.

The structure of state and federal medical care programs also creates a set of barriers to access, even for those covered by those programs. For example, a Medicaid patient in Los Angeles has relatively ready access to an acute care hospital bed if he needs it, but very diminished access to lower levels of care such as a skilled nursing facility. These levels of care are generally not available to the poor.

THE COUNTY SAFETY NET

Unique in its size, the Los Angeles County health care safety net is typical of that provided by cities and counties in many large metropolitan areas. It serves the urban poor and those otherwise without access. Thus, figures showing the size of the Los Angeles system demonstrate the need for local public sector services nationally.

Los Angeles County has a population of about 8.4 million. In 1988-89, the County Department of Health Services had an operating budget of $1.6 billion and employed 24,400 persons. The department operated 54 health care facilities: 6 hospitals, 6 comprehensive health centers and 42 health centers. The 6 hospitals, with 4,363 licensed and 2,928 budgeted beds, provided for an average of 3,039 inpatients per day, an amount 3.8% above the budgeted capacity.

In that year, the system provided 2.9 million ambulatory care visits, 300,000 emergency room visits and 1.7 million public health visits. More than 35,000 babies were born in our county hospitals, and more than 8,500 babies were born in contract hospitals at county cost. Together, this comprises more than 25% of the babies born in the county, and about 1% of the births in the nation.

Clearly, any discussion of measures to provide better access to the uninsured must consider county programs. Given the size of the existing program which the above figures document, extension and improvement of the existing county safety net would be more economical and less disruptive than replacement of that system.

COUNTY PATIENT POPULATION

County health care systems do not serve a representative cross section of the population. In fact counties serve segments of the population which some other providers would prefer not to serve.

In the Los Angeles County system, for example, most of the recipients of health care are indigents or near-indigents. Many of them live in substandard housing and are subject to substandard socioeconomic conditions generally. They tend to have limited means of transportation, which makes it critical that services be located near where they live. They often exhibit communication problems either because of language barriers or because of lack of education. Many are functionally illiterate and cannot fill out application forms. A large portion is medically unsponsored. (We use the term medically unsponsored to describe individuals who have no health care coverage of any kind, whether private, such as Blue Cross, or public, such as Medicaid.)

Although poor Blacks and Hispanics are the largest groups served in Los Angeles County, there is also a large population of recent immigrants from East Asia and the Near and Middle East including the Soviet Union. Because of cultural and economic class differences, these patients and their families manifest rare diseases, co-morbidities and behavior patterns which some noncounty providers perceive as problematic based on the lack of experience on the part of these providers in dealing with diverse immigrant cultural and socioeconomic groups.

The Los Angeles County health care system is both experienced and skilled in dealing with these class and ethnic variations. The county is acutely aware of the need for language interpreters to communicate with these patients. The county health department actively recruits employees from the same ethnic groups as the population served. A newly created computerized data base to match employee and facility with language shows, among others Amharic, Arabic, Armenian, several Chinese languages, Farsi, French (an adequate communication vehicle with many third world persons who do not speak English), Gujarati, Hindi, Indonesian, Japanese, Kutchi, Punjabi, Russian, Spanish, Swahili, Tagalog and other Philippine Languages, Thai, Urdu and Visayan.

Although many other county health care systems make the same effort to deal with a heterogeneous patient mix, private providers generally are not equipped, nor do they wish, to serve these populations. This reluctance to treat the poor and the culturally diverse has become clearer and clearer as private community hospitals and clinicians (both profit and nonprofit) continue to drop out of California's Medi-Cal (Medicaid) contracting system.

PROBLEMS OF COUNTY HEALTH CARE SYSTEMS

California law has required counties to serve as the providers of last resort for the medically unsponsored indigent. Many other states have done the same. Counties cannot turn patients away because of their inability to pay. In addition, county health care systems tend to be disproportionate share providers for Medicaid because many other providers will not accept these patients.

The property tax is the major revenue source for many counties. Voter resistance to unrestrained property tax increases combined with the rapid inflation of medical costs in the last decade make it impossible for counties to care for the medically indigent out of the traditional property tax revenue base. Federal and state subventions are also necessary.

Stable, reliable, long-term funding is also critical. The existing system of funding on a short-term, crisis basis creates an annual cycle of curtailments and threatened curtailments, often followed by restorations as last-minute, one-time-only funds are appropriated.

In Los Angeles County, for example, the Department of Health Services faced the need to reduce and close facilities in value of $55.7 million at the time of presentation of the county budget to the Board of Supervisors in May 1989. A subsequent two-year appropriation by the state legislature made these closures unnecessary. Even for 1990-91, however, the funding situation is uncertain because funding for that year depends heavily on the federal State Legalization Impact Assistance Grant (SLIAG), which the Administration has asked Congress to reduce.

One dramatic effect of lack of health care coverage is the crisis attending trauma care in Los Angeles. The trauma care network is a public-private cooperative venture involving currently 13 (10 private and 3 county) hospitals. The number of hospitals was 23 in 1985. By law, emergency rooms can not turn away patients who cannot pay. The increase in the number of medically unsponsored patients entering emergency rooms is the cause of the flight of the private hospitals from the system. The loss of a private hospital has a domino effect throughout that region of the county because the medically unsponsored served by that hospital then go to the remaining hospitals and further aggravate their financial problems. If all the private hospitals leave the system, the county hospitals will not be able to handle the load, whether the patient can pay or not.

Underfunding also affects obstetric services. Directly or by contract, the county is currently assisting at almost 50,000 births per year. Projections are that this number will grow to 60,000 by 1992. Yet, OB beds in county hospitals are filled over capacity even today. The county has identified more than $1.3

billion in capital investment needs most of which would only modernize the existing but aging current capacity. Little funding is in sight for the needed capital expansion to meet projected caseload growth.

Finally, underfunding of county health care creates hospital conditions which cause county facilities to suffer more than their private sector counterparts from staff shortages. Los Angeles County has great difficulty recruiting and keeping a number of medical professionals such as nurses, physical therapists and anesthesiologists. In the six county hospitals, 16.5% of the nursing positions are vacant. In the calendar years 1987 to 1989, the county lost 149 nurses due to retirement and another 1,427 due to resignation.

County health providers are often criticized because of the inadequacy of their underfunded programs to provide better access to all who need health care. Whatever the limitations of county health care systems may be, however, the health status of the poor would be immeasurably worse without county health care systems.

LOS ANGELES COUNTY EFFORTS AT IMPROVEMENT

Despite underfunding, counties pioneer new and improved programs wherever they can. Some examples from Los Angeles County follow.

- Los Angeles has actively sought to replace costly inpatient care with outpatient care as a means to control expenditure growth. For example, 60% of the surgery performed in Olive View Medical Center is on an outpatient basis. Also, we expanded the capacity of the emergency services system by implementing urgent care at two comprehensive health clinics for emergency room visitors who do not need a full hospital setting.

- In Olive View, the county has replaced an old facility destroyed by the 1971 earthquake with a modern state-of-the-art general acute care hospital, and has added obstetrical care to assist in the ever growing number of births.

- In 1989, the county opened a 20-bed dedicated AIDS ward at LAC/USC Medical Center.

- A project is under way for construction of a free-standing AIDS outpatient clinic at LAC/USC with capacity of about 5,000 visits per month.

- Over the past several years, the Department of Health Services has produced substantial savings by aggressively contracting services to the private sector.

- The department has adopted and initiated the implementation of a comprehensive, long-range information technology strategy.

- The department has realigned, into six vertically integrated health services networks, nine major health center operating units involving more than 45 facilities. This service-enhancing effort was performed at an annual savings of $280,000.

- The department recently implemented a county-wide pregnancy referral service using its Health Line as well as a patient services improvement program which has reduced clinic waiting times, upgraded facility appearance and enhanced staff courtesy. In the area of prenatal care, we achieved the standard of a minimum two-week wait for the first appointment on June 2, 1989. The average waiting time is now 1.8 weeks.

- The department recently won a California Association of Public Hospitals award and White House recognition for its child care center at Women's Hospital.

- The department has hired a firm that does international recruiting for hard-to-find professional personnel.

- Finally, we have created a department-wide access committee to identify barriers to access and develop strategies to address them.

RECOMMENDATIONS

- County health care systems are large-scale systems already in place which have the skills and the attitudes needed to serve ethnically and socioeconomically diverse patient populations. Any measures adopted nationally to improve access for the unsponsored must take advantage of these systems, and work to expand and improve them.

- Measures to improve access should first target groups with the greatest need and the greatest payoff for the resources invested. Prenatal, perinatal and well-baby care are particularly important because these constitute one of the areas where prevention shows the greatest cost-saving potential. Two other key areas are emergency room and trauma care and AIDS patients.

- Measures adopted should emphasize financing strategies and public-private partnerships that will work towards assuring access. In the areas where the private sector can not operate profitably, however, these measures should emphasize public interventions. They should adopt preventive programs as a method of reducing long-term catastrophic costs, and they should be oriented toward long-term, stable financing rather than the erratic financing typical of many current programs.

- Interim measures should:
  - -- eliminate Medicaid losses for the safety net providers;
  - -- redefine eligibility for existing programs to include the near-poor and those otherwise without access; and
  - -- develop programs that encourage client participation in health choices, including measures that improve bilingual access.

- Long-term solutions should promote employer responsibility by encouraging them to provide wellness programs, habit cessation programs and insurance coverage for their employees. They should promote client responsibility by improving knowledge of healthy behaviors and appropriate use of the health system.

- Los Angeles County is not committed to any one of the various possible long-term measures to assure access to all, whether extension and improvement of Medicare and Medicaid, enactment of a national mandate to employers to cover their employees, a federally funded universal insurance program, or to any particular combination of these or other measures. Any long-term solution will require the following two steps:

  - -- reaching of some national consensus on the minimum level of care which Americans can afford and are willing to pay for as a national standard for all Americans, and
  - -- adoption of federal measures which will supply this minimum level to all Americans.

- Whatever measures are adopted, they should replace current unstable, crisis-oriented, stop-gap funding with a guaranteed and stable funding basis which will assure the predictability of services over the long term.

CONCLUSION

Some may argue that the system will have to degenerate even further in order to drive consensus on the tough issues. Those providers which struggle daily to render adequate care to these vulnerable populations cannot endorse such Russian Roulette with human life. No American mother should be denied prenatal care just because she is poor. No American baby should be condemned to a lifetime of deformity simply because the child's mother could not get to see a doctor before her second trimester. Whatever be the consensus we reach about the minimum standard of care we will pay for, it must be available to all without respect to social class or economic status.

wp1.jbe.pprcom
10/18/89

SOUTHERN CALIFORNIA EDISON

TESTIMONY TO

THE PEPPER COMMISSION

UNITED STATES BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

OCTOBER 24, 1989

EXECUTIVE SUMMARY

Guiding Principles for Expanding Access

Southern California Edison shares the Pepper Commission's concern with the large and growing number of uninsured and underinsured persons in this country, and we support the goal of universal access to comprehensive health care. We feel strongly that any approaches designed to accomplish this goal should:

- Expand employment-related health benefits;
- Establish equitable provider payment levels across payers;
- Include cost sharing and utilization controls; and
- Assure equitable financing mechanisms.

All employers should provide coverage for all employees and any dependents that are not already covered by another group health plan. Small businesses should be assisted through favorable tax treatment and subsidies to make these benefits available.

Legislation should be implemented to achieve a more equitable distribution of costs across all payers. If private payers continue to subsidize the costs of Medicaid patients, health plans will be too expensive for many employers to afford.

Universal access cannot be maintained if health care costs are not controlled. To assist in moderating costs, mandatory utilization review should be a component of all plans, along with reasonable levels of cost sharing for all non-indigent persons.

Additional federal funds will be required to subsidize the costs of coverage for small business, low wage workers and the non-working poor. The financing of these subsidies should be broadly based and should not interfere with tax and other economic incentives that now encourage the adoption of health insurance.

Managing Health Benefits at Edison: A Model

Edison recently restructured its health plans and implemented a comprehensive managed care program that integrates our self-insured medical plans with our in-house claims payment system, utilization management programs, preferred provider network and primary care delivery systems. Prior to the introduction of this new program, health care costs for 54,000 employees, retirees, and their families had reached $100 million annually and were rising at 23% per year; health care costs will rise at less than 5% in 1989.

We believe that our program offers a model that may provide guidance to the Congress in designing a program of universal access. Key components include:

- Managed care emphasis, whereby benefit plan incentives encourage participants to use Edison's preferred providers, including our in-house clinics and pharmacy, and to comply with the requirements of our utilization review program.

- Employee cost sharing for all services, with limitations on total out-of-pocket spending, to involve our plan participants with their health care purchasing decisions.

- Good Health Rebate: a $10 per month premium rebate for voluntarily testing negative for five modifiable risk factors (smoking, obesity, high blood pressure, elevated serum cholesterol, and high blood sugar) or testing positive and beginning a company-approved treatment program.

- "Generation": a geriatric case management program for our retirees and their spouses that emphasizes disease prevention and provides overall coordination of treatment, including medication analysis.

Our experience demonstrates that a comprehensive managed care program integrating provider payment controls, focused utilization management, targeted preventive health applications and incremental cost sharing where appropriate can be very effective in stabilizing health care costs. Such a program also makes good progress toward improving individual health, both by identifying and reducing risk factors for major disease and by avoiding unnecessary and/or inappropriate treatment and its associated health risks.

SOUTHERN CALIFORNIA EDISON
PEPPER COMMISSION TESTIMONY

Southern California Edison is the second largest electric utility in the nation, providing service to 4 million customers in a 50,000 square mile territory in central and southern California. We furnish health benefits to our 54,000 employees, retirees and their family members.

THE NEED FOR UNIVERSAL ACCESS

Edison shares the Pepper Commission's concern with the large and growing number of uninsured and underinsured persons in this country and supports the goal of universal access to health care. As a company that has a long tradition of acting to assure that our workers, retirees and their families have access to high quality, comprehensive and affordable health care services, we find it unacceptable that the uninsured face significant barriers to receiving medically necessary treatment.

Unfortunately, the ramifications of the expanding uninsured population extend far beyond the personal hardships experienced by the uninsured in obtaining care. The entire health care delivery system is being threatened by the growing number of people without adequate means to pay for their care. For example, over half of the hospitals in Los Angeles County's once highly acclaimed trauma network have withdrawn from the system in the last two years because they could not sustain the level of bad debt and charity care associated with their emergency rooms. The results have been longer travel times to receive emergency services and overflowing emergency rooms that must frequently close their doors to additional patients, regardless of ability to pay.

Greater numbers of uninsured and underinsured patients are contributing to escalating health care costs for private payers, especially those plans that have not been effective in minimizing cost shifting through prospectively negotiated rates. Resulting higher health insurance premiums have caused many employers to cease offering medical coverage to their workers, particularly smaller and medium sized companies that have fewer opportunities for controlling health care costs. The result: more uninsured persons and more uncompensated care--a vicious cycle!

GUIDING PRINCIPLES FOR EXPANDING ACCESS

An important role of the Pepper Commission is to recommend strategies for expanding access to comprehensive health care services to the entire population. We support the goal of universal access, but feel strongly that any approaches designed to accomplish this objective should be predicated upon the following principles: (1) expansion of employment-related health benefits; (2) establishment of equitable provider payment levels across payers; (3) inclusion of employee cost sharing and utilization controls as mechanisms for controlling costs; and (4) assurance of equitable financing mechanisms.

Employment-Related Health Insurance

Some two-thirds to three-quarters of the uninsured are workers and their families. We believe that the most efficient and effective means of creating access to health care services for this population is through the extension of employment-based health insurance. Guaranteeing health coverage as a benefit of employment will assure that all workers and their dependents are covered, irrespective of their individual health risks. Any approach that severs the link between employment and health coverage, thus requiring individuals to select their own health plans, is likely to result in widespread adverse selection. This condition will only serve to accelerate and accentuate the problems of obtaining affordable coverage.

As an employer that has been providing health benefits for our workers, retirees and their families for many decades, Edison does not want to abdicate this responsibility to the government. We think we are better able to manage the health care benefits of our workforce, as we can more readily design our plans to meet our employees' unique characteristics and respond to their changing requirements. The desire to have a healthy, productive and satisfied workforce is strong motivation for us to assure that our employees and their families receive high quality care without being financially or administratively burdened. Such a direct incentive would be lacking in any government-sponsored system.

Edison believes that all employers, including self-employed persons, should be required to provide coverage for themselves, their workers and any dependents who are not already covered by another group health plan. Small businesses should be assisted through favorable tax treatment and subsidies to make the required benefits available. In addition, individuals and small groups should be afforded greater opportunities to obtain health coverage on the same basis as large employers, thus achieving the advantage of a more equitable distribution of risk.

Edison favors the adoption of a federally-established minimum benefit package that preempts all state-mandated health benefits. All health plans, including insured plans that are regulated by the State, should be required to provide the floor of benefits. These federal minimums should not otherwise change the established legal parameters under which ERISA plans function.

The minimum benefit package must be comprehensive but not unlimited in scope so that people can seek care as early as possible in the most cost-effective setting available. Medically necessary services for acute, chronic and catastrophic conditions should be covered in both inpatient and outpatient settings. Coverage should be extended to routine preventive services of proven cost-effectiveness including, but not restricted to, comprehensive prenatal and well child care services. Decisions regarding what services to cover should not be based exclusively on recommendations from providers. Employers and other payers should participate in these decisions, which should reflect current knowledge regarding the cost-effectiveness of various treatment modalities.

Equitable Payment Across Payers

Although Edison strongly supports keeping health care coverage in the domain of the private sector, we are not advocating a completely "free market" approach to controlling the costs associated with these benefits. Over the past decade, attempts to control health care costs have relied predominantly on the concept of an open, free market for health care services. This perception of an open, free market is an illusion, because consumers are largely insulated from the costs associated with their health care purchasing decisions. Health care costs are paid for by employers, and the profit margin is largely determined by providers. Hence, idiosyncratic profit motives drive our current system to generate exceptional costs without producing the commensurate exceptional value.

If universal access based on employer-sponsored medical coverage is to be achieved, we believe that all cost shifting must be eliminated. We say this in spite of the success we have had in stabilizing provider payments through direct contracting.

Currently, private health plans are subsidizing the costs of Medicaid and, to a lesser extent, Medicare patients as well as those of the uninsured. Perpetuating the inequities in the current reimbursement systems will result in private health plans that are too expensive for employers to purchase or maintain. We support legislation that will achieve a more equitable distribution of costs among all payers.

Cost Containment

Edison feels strongly that problems of access and cost are inextricably linked and must be addressed simultaneously to resolve the inequities and inefficiencies inherent in the health care system. Without universal access, we will increasingly see cost containment achieved through risk selection by carriers, resulting in a spiral of rising premiums and declining coverage. However, universal access without effective Governmental mechanisms to contain costs will be equally disastrous. Without affordable plans, small employers either will be prevented from obtaining coverage or, if required to buy coverage, may be forced out of business. Rising health care costs will inevitably be borne in part by the employees out-of-pocket or through reduced wages, thus reducing the financial well-being and health status of low-wage workers.

Edison believes that it is possible to extend access to the uninsured population without further exacerbating national health care cost problems if aggressive cost containment mechanisms are implemented. In particular, we recommend that utilization management and incremental levels of cost sharing be adopted as fundamental components of all health plans.

Considerable inefficiencies exist in our health care system, in large measure the result of reimbursement mechanisms that create strong incentives toward over utilizing health care services. Recent estimates suggest that as many as one-quarter to one-third of all medical procedures are either medically unnecessary or inappropriate. Based on Edison's experience and that of other major health plans, we know that utilization review programs can be effective in reducing the volume of such procedures, but only when plan participants are financially motivated to comply with program requirements and recommendations.

Historically, medical plan participants have been overly insulated from the costs of their treatment, discouraging consumerism and contributing to unchecked medical cost increases. Edison believes that all non-indigent individuals should share in the cost of their care. Levels of cost sharing should be sufficient to deter unnecessary utilization of services without creating an undue barrier to access. At the same time, plan participants should be protected from excessive medical costs by requiring every plan to establish a reasonable limit on individual out-of-pocket expenditures.

Financing Expanded Access

We believe it is possible that successful control of health care costs in the long-run may create enough savings to enable uninsured individuals and businesses to afford their own insurance. In the short term, however, efforts to expand coverage will require increased Federal expenditures to subsidize insurance for small business, low-wage workers, and the non-working poor. We believe the financing of these subsidies should be broadly based and should not interfere with the tax and other economic incentives that now encourage the adoption of health insurance.

MANAGING HEALTH BENEFITS AT EDISON: A MODEL

Edison recently restructured its health plans and implemented a comprehensive managed care program that integrates our self-insured medical plans with our in-house claims payment system, utilization management programs, preferred provider network, and primary care delivery systems. Prior to the introduction of this new program, health care costs for 54,000 employees, retirees, and their families had reached $100 million annually and were rising at 23% per year; health care costs will rise at less than 5% in 1989.

Impetus for Change

Edison has been intimately involved with the health care of its workers, retirees and their dependents for almost a century. In 1903, we began providing primary care services to employees and their families that resided in medically underserved areas because of their employment with Edison. Currently we own and operate 8 primary care clinics, 2 first aid stations and what may be the largest corporate pharmacy in the country. Each year we handle more than 100,000 patient visits in our clinics and process more than 250,000 prescriptions.

Historically, Edison offered very rich, first dollar medical benefits that fully insulated our employees and retirees from the cost of their treatment. Unfortunately, not only did this open-ended benefit have considerable cost implications, it discouraged our plan members from being active participants in decisions regarding their health care and from taking personal responsibility for their health and well being.

Two years ago, the company revised its philosophy regarding health benefits. The commitment to provide excellent coverage that assures access to high-quality care for our workers and retirees remained; however, we recognized that our ability to afford this coverage was predicated on plan members becoming more active and informed consumers and taking better care of themselves. As a result, we redesigned our health plans to eliminate first dollar coverage and free care and instead emphasize primary care and preventive services. We created a comprehensive managed care program to encourage our plan members to select well qualified providers and avoid medically unnecessary treatment and its attendant health risks. In addition, we created financial incentives for employees to reduce their health risks and be more prudent purchasers of health care services.

Edison's Health Care Department was uniquely postured to bring about this transition. The basic building blocks to create a strong managed care program were already in place and under our management. In addition to providing primary care services through our own salaried physicians, nurses and pharmacists, we were paying our medical claims in-house, providing utilization review services through staff nurses and physicians, and negotiating discounts with providers in the community.

Employee Cost Sharing

Requiring employees to share in the costs of their medical treatment was a major change for our company that was accomplished only because of the strong support it received from our Chairman, President and Chief Executive Officer, Mr. Howard P. Allen. Mr. Allen was alarmed by projections indicating that in the absence of significant change, the company's health care costs would grow from $100 million in 1988 to more than $200 million in 1992, an annual rate of increase of 23%. He was concerned about Edison's ability to justify such large cost increases in our biennial rate case filing with the California Public Utilities Commission. He also recognized that uncontrolled health care costs would have a detrimental impact on Edison's competitive position during a time of deregulation of the electrical industry and could adversely affect our shareholders' return on investment.

While painful to institute, and sometimes difficult to communicate, the elimination of 100% coverage was essential to achieving a health care cost containment partnership with our employees. We believe that continuing to insulate our employees and retirees from the costs of their medical care would have led to the financial demise and ultimate abolishment of our indemnity medical plan.

The Good Health Rebate and Preventive Health Account

To motivate and assist our employees and their spouses to improve their health, we included the Good Health Rebate and Preventive Health Accounts in our indemnity plan. Under the Good Health Rebate, every employee and spouse is eligible for a $10 per month rebate on their medical plan premium if they voluntarily test negative for each of five modifiable risk factors: obesity, smoking, high blood pressure, elevated blood sugar and elevated serum cholesterol. If they have an elevated risk factor and begin a company-approved treatment program to reduce this risk, they also receive the rebate.

Each year the indemnity plan allocates credits in the amount of $100 to a Preventive Health Account established for each enrolled employee and spouse. These credits, to be used for services during the year allocated, can be applied to the Good Health Rebate screening charge ($10), company-approved risk factor reduction programs and other approved prevention activities.

Utilization Management and Preferred Providers

An essential aspect of our managed care program is to assure that the services rendered are medically necessary and appropriate and delivered in the most cost-effective setting available. To be eligible for maximum reimbursement under our plan, participants must have all inpatient and many outpatient services certified by Edison's in-house utilization review (UR) team. In addition, case management services are encouraged for patients that have suffered a serious and potentially very expensive medical problem.

Maximum reimbursement under our plan is also contingent upon the use of Edison's preferred providers. To limit our financial exposure for escalating provider charges and preclude the burden of cost shifting as much as possible, we directly contracted with more than 7,500 physicians and 70 hospitals in Southern California, plus a broad array of ancillary providers.

In building our preferred provider network, we first identified and contracted with the hospitals we felt to be of highest quality in our service territory, and then we negotiated with the physician groups affiliated with these hospitals. To be in the network, physicians have to be board eligible in their specialties and subspecialties, and carry sufficient malpractice insurance. We also allow our employees and retirees to nominate their own physicians for inclusion in the network, helping to assure much greater utilization of preferred providers than is typically experienced in these plans.

Patients that receive their care from a preferred provider and comply with the plan's UR requirements pay just 10% of the negotiated fee for their care. The plan pays the remaining 90% and the provider is precluded from balance billing. Plan benefits are reduced to 70% if a patient decides to seek care outside of the network or does not comply with UR.

Our plan currently reimburses Edison's clinics and pharmacy the same as the other preferred providers. Our goal is to increase the proportion of primary care provided in-house, since we have the greatest control over the quality and costs of services delivered in our own facilities. To that end, we have expanded the population eligible to use our services to include all employees, retirees and adult dependents who are members of our indemnity medical plans. In addition, we have made a number of enhancements in the quality of our clinic services over the past two years, including strengthening the qualifications of our staff physicians. We have initiated a formal quality assurance program and are currently preparing for accreditation by the Joint Commission on the Accreditation of Health Organizations.

Health Maintenance Organization Pricing

A primary consideration in the development of our comprehensive managed care plan was to create a plan that was less expensive than any of the HMOs offered to our employees. This was done so that there would no longer be "free" HMOs, i.e., HMOs for which employees did not pay a premium. In addition, we added coverage for well child care to our indemnity plan to make the benefits more attractive to young families. Our goal was to draw back many of the younger, "better risk" individuals in our population who had migrated to HMOs.

Edison Retirees

Retirees and their dependents represent just 18% of all persons for whom the company provides benefits, but they account for more than 28% of total health care spending. We are investigating various strategies to address the special health care needs of our retirees. For example, we are piloting a geriatric case management program that expands the typical case management approach to include a review of the participant's social support system and home environment. The program, "Generation," emphasizes preventive health services and provides overall coordination of medical treatment, including medication analysis.

Also under study is a joint project with the Health Care Financing Administration (HCFA) to evaluate the feasibility of our assuming the Medicare risk for our retirees and their spouses. In this arrangement, called a Medicare Insured Group (MIG), HCFA would capitate Edison at approximately 95% of HCFA's projected cost to provide Medicare benefits for those persons that voluntarily enroll in the MIG. If we can manage the care delivered to the MIG participants more cost-effectively, we will share the savings with HCFA.

The Impact

The impact of the above changes has been dramatic. In designing our strategy, we projected that we could limit the annual rate of increase in our health care costs to 14%, compared with a historical trend of 23%. This would have resulted in $6.5 million in savings during 1989. Based on our most recent projections, we now anticipate no more than a 5% increase in health care costs from 1988 to 1989. We are running $18 million under our historical trend, which translates into $11.5 million more in savings than expected at the beginning of the year.

In addition to the immediate financial savings, we feel that our employees, retirees and their families have a greatly heightened awareness of their plan choices and the costs associated with these choices. They are becoming much more informed and aggressive consumers of health care services. In short, we believe we have begun to achieve the partnership we desire with our covered population.

Migration from the HMOs to our managed care plans has been significant. In the last year, there has been a 10% reduction in the number of employees enrolled in HMOs. And, if we look at just those employees that cover dependents, there has been a 34% decline in the number of employees selecting HMO coverage for their families. This has stabilized our indemnity plans, as the covered population now represents a more reasonable cross-section of the health care risks.

For the longer term, we have seen a positive response to our preventive health initiatives. Almost 11,000 plan participants (52% of the eligible population) were screened for the 1989 plan year Good Health Rebate. Of those screened, 8,700 (79%) received the rebate. Of the persons screened, 1,950 (18%) were found to have elevated risk factors of which they were previously unaware.

CONCLUSION

Our experience demonstrates that a comprehensive managed care program integrating provider payment controls, focused utilization management, targeted preventive health applications and incremental cost sharing where appropriate can be very effective in stabilizing health care costs. Such a program also makes good progress toward improving individual health, both by identifying and reducing risk factors for major disease and by avoiding unnecessary and/or inappropriate treatment and its associated health risks.

In spite of our initial success, we are not satisfied or assured that we will be able to maintain control over our health care costs in the long term. We are convinced that the most significant factors influencing health care costs and quality are largely outside the control of the individual employer and must be addressed through aggressive government and employer cooperation.

The first target for this cooperation should be the large and growing uninsured population. We call upon the Pepper Commission to continue your leadership role in developing a workable program that extends to the uninsured and underinsured access to our health care system. At the same time, we strongly urge that your proposals incorporate payment reform and the cost containment mechanisms necessary to assure that universal access becomes a permanent reality.

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